Mears Homecare Limited

Mears Homecare Limited - Hillingdon

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an announced inspection of Mears Homecare Limited – Hillingdon on 30 November, 1 and 3 December 2015. We told the provider two days before our visit that we would be coming because the location provides a domiciliary care service for people in their own homes and staff might be out visiting people.

Mears Homecare Limited – Hillingdon provided a range of services to people in their own home including personal care. At the time of our inspection 300 people were receiving personal care in their home. The majority of people using the service had their care funded by their local authority. People could also pay for their own care.

This was the first inspection of the service since Mears Homecare Limited took over the service from Care UK and registered with the CQC on 19 November 2014.

The service did not have a registered manager. 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 provider had a process for the recording of incidents and accidents but the information relating to any actions taken was not recorded on the system.

The records produced relating to the administration of medicines were not accurate. We saw the care workers did not record all the medicines that were administered.

The provider had generic risk assessments in place but they had not identified possible risks in relation to specific issues for people using the service and had not provided care workers with guidance on how to reduce these risks.

People using the service and care workers had concerns regarding the number of care workers available during the weekend, which led to late visits and staff taking on extra calls.

Care workers did not have regular supervision with their manager or an annual appraisal.

There was a policy and training in relation to the Mental Capacity Act 2005. However, the provider did not ensure appropriate actions were taken when a person using the service had been identified as unable to make decisions about their care.

The provider had a complaints policy and procedure in place but complaints were not responded to in an appropriate timeframe.

The provider had limited systems in place to monitor the quality of the care provided. These did not provide appropriate information to identify issues with the quality of the service.

Records relating to care and people using the service were not completed accurately to provide a current picture of the person's needs and the support provided.

The care plans did not identify how the person wished their care to be provided. We have made a recommendation in relation to person-centred care planning.

People using the service felt the service was not well-led and this was supported by feedback from care workers.

People using the service felt safe when they received care and support. The provider had processes in place to respond to any safeguarding concerns. There were safe practices in place in relation to recruitment of care workers.

Care workers had completed a range of training that had been identified as mandatory by the provider.

People we spoke with felt the care workers were caring and treated them with dignity and respect while providing care. Care plans identified the person's cultural and religious needs.

We found a number of breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking action against the provider for the breach of the Regulations in relation to need for consent (Regulation 11), the safe care and treatment of people using the service (Regulation 12), receiving and acting on complaints (Regulation 16), the good governance of the service (Regulation 17) and staffing (Regulation 18). We will report on it when our action is completed. You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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. Medicines were not always recorded on a medicines administration record (MAR) chart when administered by care workers.

Risk assessments relating to people's specific support needs and associated guidance for care workers were not in place.

People using the service felt safe but there were not always enough care workers to meet their care needs appropriately and safely.

The actions identified following incident and accidents were not always recorded.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. Staff had not received the necessary support they required to deliver care safely and to an appropriate standard.

The provider had a policy in place in relation to the Mental Capacity Act 2005 but they did not have procedures in place to ensure appropriate actions were taken when a person using the service had been identified as unable to make decisions about their care.

Care workers completed a range of training identified as mandatory by the provider.

There was a good working relationship in place with healthcare professionals who provided support for people using the service.

Is the service caring?

Good

The service was caring. People we spoke with felt the care workers were caring and treated them with dignity and respect while providing care.

Care workers supported people to maintain their independence but there was no guidance in the care plans explaining how this

should be done.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. The provider had a complaints policy and procedure in place but complaints were not responded to in an appropriate timeframe.

The care plans did not identify how the person wished their care to be provided.

People using the service had been sent a questionnaire to gain their views of the care provided.

Is the service well-led?

Inadequate

The service was not well-led. The provider had limited systems in place to assess the quality of the service being provided. They did not provide adequate information to identify areas for improvement.

Records relating to care and people using the service were not completed accurately to provide a current picture of the person's needs and the support provided.

People using the service and care workers felt the service was not well-led. Care workers felt supported by their line manager but not by the wider organisation.

Mears Homecare Limited - Hillingdon

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 the 30 November, 1 December and 3 December 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available.

Two inspectors undertook the inspection on the first day and one inspector for the following two days. Two inspectors carried out telephone interviews with people using the service, their relatives and care workers.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the notifications we had received from the service, records of safeguarding alerts and previous inspection reports.

During the inspection we spoke with the operations manager, the care manager, recruitment manager, branch trainer and a care coordinator. We reviewed the support plans for 12 people using the service, the employment folders for 12 care workers, the training and supervision records for 45 care workers and records relating to the management of the service. After the inspection visit we undertook phone calls to 21 people who used the service, three relatives and received feedback through telephone interviews and via email from 11 care workers.

Inadequate

Is the service safe?

Our findings

People were at risk because the provider had not taken action when the person receiving support had an accident or action to prevent these reoccurring. The provider had a process in place for the recording and investigation of any incidents and accidents but not all the information relating to the action taken was recorded on the forms. The care manager was unable to provide any original incident and accident forms that had been completed by care workers. We saw information regarding incidents and accidents had been recorded on a computerised system but the care manager was unable to confirm that all reportable incidents and accidents had been recorded. We looked at the computerised records for three incidents and saw that two records only had details of the event with no information relating to an investigation or any required actions to reduce any risks.

We saw that one record relating to a medicine administration error identified that the care worker required additional medicines management training. We checked the employee record and the training records but found that the care worker had not completed the identified training since the incident occurred. This was confirmed by the care manager. This meant that incidents and accidents were not reviewed and monitored by the senior staff, so that any trends or patterns could be identified.

The above paragraphs demonstrate a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a policy and procedure for the administration of medicines but the care workers were not recording the administration of medicines accurately. Care workers had to record the medicines they had administered or supported the person to take on a medicines administration record (MAR) chart. We looked at the care records for five people who had support with their medicines. The care plans for each person stated that the prescribed medicines should be administered daily by the care workers. The MAR charts that were available for each person indicated that the care workers had not recorded the administration of medicines on numerous occasions. The MAR charts for one person indicated they had seven prescribed medicines. We saw that the care workers had not recorded the administration of medicines on 11 days during September 2015 for this person. The prescribed medicines included Warfarin and we saw that the MAR chart did not specify the dosage administered. There were no reasons given for these gaps in the recording of medicines that had been administered.

We looked at the MAR charts for another person and saw on seven occasions during July and August 2015 the administration of all six prescribed medicines was not recorded. We also saw from the MAR chart and daily records that the person had run out of prescribed medicines on the 22 and 23 July 2015. The records showed the care worker had to contact the pharmacy over the two days to arrange delivery of the new medicines.

This meant that the provider could not ensure that people had received their medicines as prescribed, and one person did not receive prescribed medicines as they had run out.

The above paragraphs demonstrate a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had general risk assessments in place for people using the service but detailed risk assessments for specific issues were not in place. We looked at the care folders for 12 people and saw each person had a general risk assessment document which covered day to day living. There were also a number of issues that had been identified in individual assessments and care plans that were specific to each person. Possible risks were identified but an assessment had not been carried out and guidance for care workers on how to reduce these risks had not been provided. These issues included visual impairment, use of a hoist, increased risk of pressure sores, falls, catheter use and diabetes. We saw that the local authority had identified that one person could exhibit aggressive behaviour and the provider should carry out a specific risk assessment before care started. The provider did not carry out a specific risk assessment as requested or mention any risks identified by the local authority in the person's care plan. This meant that care workers were not aware of any increased risk in relation to the person's specific support needs and how to reduce these risks. This resulted in an increased risk that people's needs may not be met in a safe and appropriate way.

The above paragraph demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they were happy with the number of care workers available during the week but there were a number of concerns about the care worker provision at weekends. One person said "I don't know who or what time they (referring to carers) are coming. Weekends is the problem, especially the lunch time, they have not turned up until 1.30 or 2pm sometimes. They just do a sandwich but by that time I am hungry." Another person commented "My week day carers are very good, I know them and they come on time. The weekend I have all different carers, I never know who is coming. The agency say, 'I will check up to see what is happening', but they never do. The lunchtime call last weekend did not arrive until 2.30pm and I was hungry. It's very dodgy at the weekend with staffing." One person explained that their regular weekend care worker had been given new visits and was no longer supporting them. The person said they preferred their breakfast at 8am but at weekends the care workers often arrived at 11 am with a lunch visit a couple of hours later. One person told us it was important for them that the care workers arrived on time as their medicines had to be taken at a specific time due to their medical conditions. A relative also confirmed their family members required their medicines to be given at specific times. They both confirmed that usually the care workers at the weekend were late for some of the visits.

Nine care workers we spoke with told us there are frequent shortages of care workers, especially, in the evenings and weekends. Consequently other care workers were asked to cover additional visits which caused a lot of pressure on them. One care worker said "Weekends are the worst, everyone is off and you may be doing much more work, sometimes without a break. We always raise this issue with management but nothing changes." Another care worker stated "There are no consequences for people who frequently miss work on weekends and others need to cover. I know about it as people are quite open about this (missing weekend shifts) and there is no way people are ill that often. I often have to attend other calls as there is no cover. If I said no they (managers) would say I have nobody else to do it. I feel I cannot refuse."

This meant that people's needs were not being met as planned because the care workers were not arriving at the agreed times.

The above paragraph demonstrates a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The number of care workers required for each visit was decided by reviewing the information provided in the local authority referral and during the initial meeting with the person planning to use the service.

All the people using the service and relatives we spoke with said that they felt safe when their care workers were in their home and they had no concerns about their safety. We saw the service had policies and procedures in place to identify how concerns regarding the care being provided should be responded to appropriately. This included a whistleblowing policy for care workers and other staff. Care workers completed training in relation to safeguarding adults as part of their induction and an annual refresher course.

The service followed safe recruitment practices. The recruitment manager explained that when the service was contacted about a care worker vacancy they would carry out checks either online or by telephone to ensure the applicant met the criteria based upon location and existing skills. The applicant would then be invited to attend an interview and skills test. The interview included competency based questions and applicants completed literacy and numeracy checks. The applicant was asked to provide the details of two references from previous employers or character references from people who have known them for at least five years. The new care worker could not start to shadow an experienced care worker until a Disclosure and Barring Service (DBS) check had been received to see if they had a criminal record. We saw from the application forms we looked at that the applicants were not asked to provide any information relating to their education and any qualifications during the recruitment process. We raised this with the operations manager who explained that they were aware that this section was not included in the application form and they would be reviewing this. During the inspection we looked at the employment records for 12 care workers and saw the provider had received at least two suitable references for each care worker and a check for any criminal records had been completed. This meant that checks were carried out on new staff to ensure they had the appropriate skills to provide the care required by the people using the service.

The operations manager confirmed the service had up to five care workers which were employed by another home care service who helped them cover visits when they were short staffed. We saw the information provided by the other home care service about the care workers included their contact information, photograph, when they completed any mandatory training and details of their DBS check.

Requires Improvement

Is the service effective?

Our findings

We saw people were being cared for by care workers that had not received support to deliver care safely or to an appropriate standard. The operations manager explained that all staff should have one supervision meeting with their manager, an appraisal, and two observation assessments while providing care per year. We looked at the employment records for 12 care workers that had started working for the service since July 2015. We saw eight care workers had not had a supervision session or observation based assessment since they had completed their induction. The operations manager confirmed that, from a total of 140 care workers, 55 had not had a supervision session during the previous year. They also told us 56 care workers had not had an annual appraisal. This meant training and development needs may not be identified to ensure staff had the appropriate skills to provide safe care.

The above paragraph demonstrates a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

The provider had a MCA policy in place but actions were not taken to meet the requirements of the Act when a person had been identified as lacking mental capacity to make decisions. The operations manager explained that the provider had a toolkit that could be used to make referrals to the local authority to request mental capacity assessments and plan best interest discussions but this was not being used. The care manager and a care coordinator confirmed that assessments and referrals were not usually carried out if concerns were identified relating to a person's mental capacity. We looked at the local authority referrals for two people and we saw they had both been identified as not having capacity to make decisions. This had not been included as part of the person's care plan and it had not been identified if there were Lasting Powers of Attorney (LPA) in place. A Lasting Power of Attorney in health and care matters legally enables a relative or nominated person to make decisions in the person's best interest as well as sign documents such as the support plan on their family member's behalf. We saw the relatives of each were agreeing the care plans and providing feedback on the care provided with no involvement of the person using the service. There was no information on who could make decisions in each person's best interests.

This meant that processes that were in place were not being used to ensure these people's rights were being protected.

The care coordinator explained when people had their initial assessment they were given an information sheet which included the contact details for an advocacy service. We looked at this leaflet and saw the contact details referred to the Scottish Independent Advocacy Alliance as the information sheet was for the Mears services based in Scotland. People were not given information about advocacy services in the local area.

The above paragraphs demonstrate a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The branch trainer confirmed care workers completed training about the MCA as part of their induction. We asked the care workers if they had completed training on the MCA and if they understood what it meant in relation to providing care. The care workers confirmed they had completed the training and they needed to support people in making decisions relating to their care whenever possible.

The branch trainer explained new care workers completed a five day induction course which included sessions based upon the new Care Certificate. The Care Certificate identifies specific learning outcomes, competencies and standards in relation to care. The branch trainer told us earlier in the year they had requested the new Care Certificate workbooks which had been developed by the provider but these had not yet been delivered. We saw the service had a dedicated training room which included equipment for moving and handling training. New care workers also shadowed an experienced care worker for up to seven hours depending on their previous experience. We saw the shadowing assessment forms for ten new care workers who had joined the service since July 2015. The forms were completed by an experienced care worker identifying what care activities were completed during each visit during the shadowing sessions. They provided feedback on the competency of the new care worker and if they would benefit from additional training.

The branch trainer confirmed that care workers completed a range of refresher training courses identified as mandatory for all care workers by the provider. These included infection control, moving and positioning, food hygiene, catheter care and first aid. We looked at the training records for 45 care workers and we saw all the care workers had completed all the refresher courses identified as mandatory.

We asked people using the service if the care workers usually arrived at the time agreed and stayed for the whole scheduled visit. People told us "The care workers do not always arrive on the dot, a bit late sometimes, but it's ok", "I am very happy with my carers, they come on time and stay the time they are supposed to" and "My carer is always on time, it's a very satisfactory arrangement." Other people said "They stay their time, as they have this system where they have to clock in and out", "I have never really had a problem with them not turning up, they are always here" and "At times they are five minutes late, but never really more than that, carers stay their time." A relative commented "The carers are always very apologetic when they are late and my family member does not blame them."

We saw care plans indicated if the person required support from the care worker to prepare and/or eat their food. Some of the care plans we looked at indicated what the person preferred to eat and drink.

We saw there was a good working relationship with healthcare professionals who also supported the people using the service. The care plans we looked at provided the contact details for each person's General Practitioner (GP) and other health professional involved in the persons care. People using the service told us the care workers would contact their GP and leave notes for the district nurse if they had any concerns about the person's health.

Good

Is the service caring?

Our findings

We asked people if they felt the support they received from the care workers helped them to maintain their independence. People told us "They support with practical things and what I have difficulty with, this keeps me independent" and "I try to do what I can for myself and the carers respect this." Another person said "My carer is very thoughtful, helps me remember what I am supposed to be doing by writing it all down for me so I know. They never leave me stranded." A person using the service explained the care workers helped with all the tasks she needed support with but "I like to be independent and carers respect this by enabling me to prepare my own hot meals and only helping if I ask them." One person told us they had a key safe but they preferred care workers not to use it and they respected this. The person let the care workers in using a buzzer intercom which gave the person a feeling of independence and control.

We saw the care plans had sections to provide care workers with background information about the person. These sections included who was important to the person, their life history and memories. We looked at the care plans for 12 people and saw that these sections were either not completed or had limited information.

The care plans identified the person's cultural and religious needs. The person's preference in relation to the language spoken by care workers was recorded as well as if their wishes relating to the gender of the care worker providing their support. The name they preferred to be called by care workers was also identified.

All the people we spoke with told us they felt the care workers treated them with dignity and respect. One person told us "I am happy with my carers and the support received, all carers are lovely and treat me with respect and dignity." Care workers we spoke with said maintaining the person's dignity and privacy was at the forefront of any care they provided. All the care workers said they make sure people are covered when receiving personal care and that no one else was present in the room while this took place. They would also listen to the person's wishes and stop providing personal care if requested to during a visit. Care workers also told us they were respectful of people's confidentiality and would not discuss their care needs in an inappropriate manner.

People using the service and relatives were asked if they felt the care workers were kind and caring when they provided support. One person told us "The care workers always ask me 'how are you today, what can I do to help you'. I can honestly say they brighten up my day. They never impose themselves on me, they are really helpful." Another person said "My new carer, I have shaped her, it's improving. All carers are polite and courteous; despite using the key safe they always ring and call out to let me know they have arrived." A person commented "Yes I am very happy with my carers, they are kind girls." Another person told us "My carers are just perfect, I am quite happy with them. I look forward to them coming in, they brighten up my day. I am not sure what I would do without them, I would not be able to manage." One person said "I can honestly say I have never had a problem, it's all tickety-boo really."

All the care workers we spoke with explained how they would promote a very caring and loving approach towards their work and people they supported. Care workers told us "When you do this job you get to know people and you make the connection with them and you care for them" and "In this job you need to be

gentle and treat people as you would like to be treated."

Requires Improvement

Is the service responsive?

Our findings

Two people told us they had made complaints but were unhappy with the way they were dealt with. We saw people using the service were given a leaflet with general information about the complaints process but this did not include the contact details of the office. The provider had a complaints process and procedure in place but this was not always followed. The care manager told us the majority of complaints were received via the local authority on behalf of the person whose care they funded but people using the service could also make complaints on their own behalf. When a complaint was received a summary sheet would be completed with details of the issues raised, if an acknowledgement of receipt had been sent and the date by which a response should be sent. The care manager explained that the local authority expected a complaint response to be sent within 10 days. The provider's policy also stated that complaints should be dealt in full within 10 working days. One local authority informed us they had sent 186 complaints to the service during 2015 and the care manager confirmed this. We looked at the records for 10 complaints that had been received during the previous three months. We saw the information was not always completed in full and some of the complaints did not have a record of any actions that were identified. The care manager explained that a large number of complaints received during 2015 had not been responded to within the local authority timescales which was confirmed by the local authority.

This meant the provider had not responded to complaints in a timely manner and identified actions required to improve the service

The above paragraph demonstrates a breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Eight care workers we spoke with were not aware of any formal policy and procedure related to possible complaints by people using service or their relatives. However, when asked what they would do if they received a complaint they told us "I would first find out what this is about and try to resolve while on the call" and "I would call my coordinator to let them know or I would advise clients to call the office themselves." Two care workers said there was a complaint form in the care folder in the person's home.

People's care planning was not always done in a person centred way to take account of their experiences and preferences. The care manager explained they did not complete a separate assessment of a person's needs before care was started. The care plan was written during the initial assessment with the person and a copy was left in their home at the end of the visit. The care plan was developed through discussions with the person, their relatives and from information received in the local authority referral. We looked at the care plans for 12 people and saw the document was not always completed in full. There was a section for the care coordinator to identify how the person wanted their support to be provided and their daily routines. We saw in most care plans the information in this section was a list of tasks for the care worker and did not identify how the person wanted their care provided. We saw one care plan referred to the activities for each visit including 'walk to bathroom, full strip wash, apply cream' in a list. This did not describe the person's wishes in relation to how they wanted their care provided.

The care plans were not in a format which was accessible to everyone using the service. Some people had visual and cognitive impairments which made it difficult to read a standard document.

We asked people using the service if they were aware of their care plan and if they were involved in reviewing it. One person told us their care plan stated care workers were to make them comfortable and look after the person's pet. They said "I had two pets and they are both dead, so that will tell you the care plan is not up to date." Some people were unsure about the content of their care plan but were happy with the support they received from the care workers. People said "I think I have a care plan, but they (referring to the carers) do what needs doing, so I am not worried about a care plan" and "I am not sure about a care plan. The carers do whatever I want anyway – so it's not a problem."

One person using the service and one relative we spoke with confirmed they were involved in the writing of care plans. The person said "Yes I was asked what I wanted and I told them, there is paperwork somewhere, a care plan or something. My carer deals with it." The relative confirmed they had discussed the support their family member required as they were unable to be involved.

We asked the care workers if they were aware of the care plans for the people they supported and how often they read them. All the care workers we spoke were aware of the care plans and risk assessments that were placed in care folders in the person's home. The frequency of how often they were looked at varied between care workers. They explained this depended on how well they knew person they visited and if they were aware of any changes to person's needs.

The care manager confirmed that care plans were reviewed annually or sooner if there had been a change in the person's needs. The care plans we looked at had been recently reviewed.

The operations manager explained that a questionnaire had been sent to people using the service during the month before the inspection. The questionnaire had been sent out by another location so we were unable to see which questions had been asked. One person we spoke with confirmed they had received their questionnaire that morning.

We recommend the provider review guidance on person-centred care planning and how to produce care plan in suitable formats.

Inadequate

Is the service well-led?

Our findings

The provider had not identified, managed and mitigated risks to people. During the inspection we identified a range of issues including the lack of specific risk assessments, management of medicines and reporting of incidents and accidents. These had not been identified by the provider using their existing processes. The provider did not have a robust system of audits and checks in place to review the quality of the care and support provided. The operations manager explained that checklists were completed to ensure all the appropriate paperwork was in place for people starting to receive care and the recruitment of new care workers. Their forms were not always completed in full to include if the required documents were on file and if any actions were required. We also saw that some of the staff audit forms had been completed up to 10 months after the care worker had started with the service. Therefore the checks had not been carried out during the recruitment process.

The care manager confirmed that a selection of records made by care workers describing the support provided was checked by care coordinators. We saw that if the care coordinator identified any issues, actions were not always recorded. If any actions were identified the forms did not indicate if these had been completed.

The care manager also explained that the computerised records for the arrival and departure times for care workers were only checked to confirm if a care worker had attended in relation to payroll. Care workers used a telephone based system to record the time they arrived at a person's home and when they completed the visit. They told us the computer system indicated when a care worker had not confirmed their arrival at a person's home. This was checked by the payroll manager to ensure care workers were being paid for the correct number of hours worked. No other checks were carried out to ensure the care workers were visiting the person at the times agreed in their care plans. During the inspection we looked at the records relating to the arrival and departure times for four care workers over one week in November 2015. We saw the majority of visits were made within 30 minutes of the agreed time but we saw the records for one care worker which showed they had arrived an hour or more late on ten occasions during the week and more than an hour early for 12 visits over the same period. We discussed this with the care manager who told us the agreed visit times may be incorrect on the records and they would review the information.

We asked the operations manager and care manager if any other audits were carried out in addition to the document checklists and the daily record checks to monitor the quality of service. They informed us that if any other checks were carried out these were done informally and were not recorded. This meant that there were limited systems in place to monitor the quality of the care and these had not identified the issues described in this report.

The above paragraphs demonstrate a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records relating to care and people using the service were not completed accurately or stored in an accessible manner. During the inspection we saw information from the local authority referrals and risk

assessments was not transferred to the person's care plan. We saw one risk assessment identified a person was allergic to an antibiotic but this was not recorded in the person's care plan. The local authority referral for another person indicated they could experience periods of aggressive behaviour but this information was not noted in the care plan. The risk assessment for this person stated there was no potential for aggressive behaviour from the person using the service. The local authority referral for another person indicated that they had a visual impairment but the care plan stated the person had a hearing impairment. This meant the records used by the care workers did not provide appropriate guidance on the specific supports needs of the person.

We looked at the care folders for 12 people using the service and found the current care plans and risk assessments were not clearly marked. The folders had previous care plans and risk assessments but these were not clearly marked with the date so it would be necessary to look at all the documents to locate the current records.

The care manager told us the MAR charts should be collected each month and the daily record logs returned to the office when the book was completed. We saw that the care folders did not have the recently completed daily records and MAR charts on file. These records for one person had not been collected since February 2015 with the most recent records being June 2015 for other people. This meant that the records could not be reviewed regularly to ensure the person was receiving the appropriate support and the care worker was recording information accurately.

We saw safeguarding concerns that had been received had been recorded as complaints and placed in the complaints folder. During the inspection we saw the records for two safeguarding concerns both had detailed information regarding the issues and included copies of correspondence. These records had not been updated to identify any actions that were taken and the outcome. We were unable to look at any other safeguarding records as they had been put in the complaints folder and were not easily identifiable.

During the inspection we saw that paperwork from the previous provider and the current provider were being used at the same time. This meant there were two formats for care plans and risk assessments being used to identify what support was required.

The above paragraphs demonstrate a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of the inspection the service did not have a registered manager in post. The service had been transferred to Mears from Care UK during 2015 and a registered manager had not been in post since August 2015. The operations manager told us the provider was planning to recruit a new registered manager in the coming months. The care manager explained she had been employed as a care coordinator by the service and had been promoted to the care manager role in August 2015. She confirmed she had not received any induction or training in relation to the new role. During the inspection we saw the care manager was the most senior person in the office and was responsible for the day to day management of the service.

The above paragraph demonstrates a breach of Regulation 5 of Registration Regulations (Schedule 1) Registered Manager Condition.

The care manager confirmed that the provider had sent copies of new care plan, risk assessment and review forms to the office but the staff had not been trained on how to use these forms correctly. They confirmed that the care coordinators and other office based staff had not received training in relation to the procedures used by Mears since they took over the service.

We received mixed feedback from people using the service and relatives when we asked if they thought the service was well-led. One person using the service told us "No, you have to be joking, there is no organisation in that office, they have the carers all over the place with no travel time. There are too many people in the office and no one knows what is going on, well that's my opinion anyway. I've told the office as well, it's not fair on the carers." Other people said "The office never ring, I have to ring them" and "The office occasionally ring, but they are not very good at calling or letting you know what is happening, that is where they fall down." Other people using the service gave a more positive comment "It's getting there, but there is room for improvement. I think the new lot (referring to Mears) are doing their best. I have to give due credit to Mears, they are trying to improve things" and "I am getting a good service and the office is well run." A relative commented "At the actual point of delivery of the care it's great, but it's the organisation of it all that lets it down."

We asked the care workers if they felt the service was well-led. Four of the care workers said the service was not always well led. Two care workers were not sure who the manager was or they had only met them recently. Five care workers told us concerns or queries were often not responded to and were "Brushed under the carpet". For example, one care worker said they complained about frequent (up to 4 times a week) lack of a second worker on the calls, as per the care plan, however there was no change to the situation. Another care worker mentioned their apprehension in visiting a client whose behaviour was making them feel uncomfortable. Although the same concerns were raised by other care workers they were still allocated to do the visit as "there was nobody else to do it".

We asked care workers if they felt supported by their manager and we received mixed feedback. Three care workers gave us negative feedback "Sometimes I feel supported, sometimes I don't. for example when a person died but we didn't get any support and were told to come to work", "I didn't feel supported and when something caused a lot of stress for me I asked to change the area I go to see clients in but they did not listen and were not flexible" and "I am trying to avoid them, I don't want to have any contact with them".

Six care workers told us they had good relationship with their line manager and felt supported. The care workers said "My coordinator is excellent, I asked not to change my rota without telling me first which she acknowledged and has done. If she wasn't there additional calls would be added"; " My line manager I can give a glowing report, we communicate properly and she made changes to the rota, but generally the communication is not good" and " I am quite happy, had no issues, had no problems". Another positive comment was "Yes I feel supported by my manager, everything I tell her she follows through." One care worker told us they had only recently started with the service and had met the manager. They said "I know my coordinator I meet her every week and we talk about the job".

All the care workers we spoke with said things had slightly improved since the new provider had taken over nevertheless, the majority of workers said that although they had a good relationship with their line manager they did not always feel supported by the service. Amongst the issues identified included poor communication with the office, additional calls being assigned without prior discussion, lack of response to staff concerns, no flexibility in approach when dealing with staff requests and absence of systems in place to address frequent staff absences.

Four care workers told us since the new provider took over the service communication have improved; however, it is still a big concern. One care worker said "When I call my coordinator the message is often not passed on. It makes me feel frustrated" and "When I call during weekend nobody answers the phone, in case of emergency I cannot get support. Clients also complained they cannot get through. This makes us look bad as a service."

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 5 Registration Regulations 2009 (Schedule 1) Registered manager condition There was no registered manager in post.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not acted in accordance with the Mental Capacity Act 2005. Regulation 11 (3)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not assess the risks to the health and safety of service users of receiving care and do what is reasonably practicable to mitigate any risks. Regulation 12 (2) (a) and (b) The provider did not ensure the proper and safe management of medicines. Regulation 12 (2) (g)

The enforcement action we took:

We asked the registered provider to undertake weekly audits of medicine administration record charts, risk assessments, service user needs and care plans. The registered provider must also produce an overview of the results of any other audits carried out each month. The registered provider must send the Care Quality Commission a monthly report which states an overview of the audits completed and the action taken or to be taken as a result of these audits.

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

by service users and other persons in relation to the carrying on of the regulated activity.

Regulation 16 (2)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not assessed, monitored and improved the quality of the services provided. Regulation 17 (2) (a) The provider did not have a process in place to assess the specific risks to the health and safety of services users and do all that is reasonably practicable to mitigate any such risks. Regulation 17 (2) (b) The provider did not have a system in place to maintain an accurate, complete and contemporaneous record in respect of service users. Regulation 17 (2) (c)

The enforcement action we took:

We asked the registered provider to undertake weekly audits of medicine administration record charts, risk assessments, service user needs and care plans. The registered provider must also produce an overview of the results of any other audits carried out each month. The registered provider must send the Care Quality Commission a monthly report which states an overview of the audits completed and the action taken or to be taken as a result of these audits.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not deploy sufficient numbers of suitably qualified, competent, skilled and experiences persons. Regulation 18 (1) Also the provider did not ensure staff received appropriate support and appraisals to enable them to carry out their duties.

Regulation 18 (2) (a)

The enforcement action we took:

The registered provider must not accept any new service users to Mears Homecare Limited – Hillingdon, Unit 2, Brook Business Centre, Cowley Mill Road, Uxbridge, Middlesex, UB8 2FX without the prior written agreement of the Care Quality Commission.