Mears Care Limited

Mears Help to Live at Home Wiltshire

Inspection report

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Ratings

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

Overall summary

This inspection took place on 3, 4, 11 and 16 December 2014. This was an announced inspection which meant the provider knew two days before we would be visiting. This was because the location provides a domiciliary care service. We wanted to make sure the manager, or someone who could act on their behalf would be available to support our inspection.

Mears Help to Live at Home Wiltshire is a large domiciliary care agency which provides care and support to people in their own homes on a short and long term basis. The agency manages the local authority's Help to Live at Home contract and had expanded by purchasing three domiciliary care agencies within the local area, earlier in the year.

Summary of findings

The agency had a newly appointed manager and at the time of our inspection, they had been in post approximately two months. They are not as yet the 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 newly appointed manager told us they were in the process of completing their application to become the registered manager.

We carried out an inspection of this service in June 2014 in response to concerning information we had received. We issued a warning notice and four compliance actions to ensure the provider made improvements as we identified widespread non-compliance, in all of the five outcome areas we looked at. There were shortfalls in people's care, including missed visits and the administration of medicines and inadequate staff support, training and the management of complaints. The significant shortfalls in provision had predominantly been caused by the transfer of the additional agencies, which had not been managed well. The provider sent us a detailed action plan which described how they were going to make improvements.

To ensure improvements had been made, we carried out another inspection of the service in August 2014. We identified further widespread shortfalls in care provision, such as missed calls and inadequate care planning, which placed people at risk of significant harm. The warning notice which we had issued in June 2014 had not been complied with. Due to the risk of significant harm to people's safety, we issued a Notice of Decision, which restricted the provider from accepting any new care packages unless with our prior agreement.

We undertook this inspection to review the restriction and to ensure people's safety was assured.

Improvements had been made to the service. However, there was a strong sense that these needed to be embedded and sustained over a period of time. There was concern that the agency would revert back to how it was, in particular when our regulatory work was lessened and seconded managers returned to their previous roles, within the organisation. In addition, people, their relatives and staff were concerned that the potential lifting of the restriction of accepting new care packages would create increased workload, without the capacity to be manageable. Following the inspection we met with the senior management and Wiltshire County Council to discuss these concerns. Discussion took place to ensure that new care packages were offered in a planned way and that there were sufficient staff to meet these new packages.

Whilst improvements had been made to the service, the administration of people's medicines was not safe. The records were handwritten and had not been signed or countersigned to show that they were accurate. Instructions for the medicines were not written in full. This increased the risk of error. Staff had not consistently signed the record to demonstrate the medicines had been given. Some medicines were left for people to take later but there were no assessments to identify and address the potential risks of this. You can see what action we told the provider to take at the back of the full version of the report.

Assessments regarding potential environmental risks to people had been completed. However, some assessments contained basic information and did not identify specific risks associated with people's health care conditions. This included the risk of pressure ulceration and the refusal of staff support. The absence of these assessments did not ensure effective risk management, which increased people's risk of harm. You can see what action we told the provider to take at the back of the full version of the report.

Staff were aware of encouraging people to be involved with making day to day choices and decisions. However, staff's knowledge about mental capacity and the implications of this within their practice was limited. Most of the staff could not recall having any training about the Mental Capacity Act. The training was not detailed in any records or on the staff training plan. The limitations of staff's knowledge increased the risk of people being deprived of their liberties. You can see what action we told the provider to take at the back of the full version of the report.

Many care systems had been given a dedicated focus to ensure improvements. However, all were in their infancy and required time to be developed and sustained. For example, within the last three months, manager's had met with each person who received a service, to

Summary of findings

undertake an updated assessment of need. This information was then used to develop a plan of care, which accurately reflected the person's needs, preferences and the support they required. The development of updated care plans meant that staff had access to more information about people, which enabled a more effective service. Time was required to ensure all care plans were updated, as people's needs changed.

Since our last inspection, the number of missed calls had significantly reduced. An electronic monitoring call system had been installed, which required staff to log in and out when they arrived and left a person's property. If they did not do this on arrival, within an identified timescale, the office would be alerted to a possible missed call. This enabled action to be taken before the risk of harm. Any missed calls were being monitored and fully investigated with the aim to reduce occurrences further.

People told us the timing of their visits and the consistency of staff supporting them had improved. However, there were some comments that indicated these areas could be further developed. Some people commented they still received support from unfamiliar staff and there was some lateness, which caused anxiety and frustration. People and their relatives were generally positive about the staff. They said their privacy and dignity was maintained unless it was impacted upon by the inconsistency of staff allocated to them. There were some negative comments about individual staff, which some people had raised with the agency.

Staff told us they felt better supported and communication systems had improved. Staff were receiving supervision so that issues and work performance could be discussed. This system had enhanced morale although was not available to all staff, such as those in the office. It also required greater time to become established. Records showed what areas had been discussed but action plans were not clear and needed greater clarity. All staff had received updated mandatory training but training specific to people's needs and their health conditions, was in the process of being developed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

People's medicines were not managed in a safe way.

Individual risks to people's safety were not always identified and appropriately reported and acted on.

Improvements had been made to the reliability of the service to enhance peoples' safety. Potential missed calls were being identified and managed appropriately before any risk of harm.

Staff had received updated safeguarding training and demonstrated they would raise any concerns, to reduce the risk of harm to people.

Requires Improvement

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

People told us improvements had been made to the service and things were settling down. Work had been undertaken to the scheduling of visits which enabled people greater staff consistency.

Staff had received updated mandatory training to increase their knowledge and skills. However, training did not relate specifically to people's needs and their healthcare conditions.

A system to formally support and supervise staff had received dedicated focus. Greater time was required to ensure the system was fully embedded and successful.

Requires Improvement

Is the service caring?
The service was caring.

People and their relative's views of the staff varied. The majority were positive and described staff as kind, respectful, caring, and helpful. Some comments about staff were more negative.

Staff had an understanding of person centred care and aimed to provide this. People were encouraged to be involved in their care and told us their privacy and dignity was maintained. However, the inconsistency of staff sometimes impacted upon this.

Good

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

Requires Improvement

Summary of findings

Work had been undertaken to ensure each person had up to date assessments and care plans in place. This enabled staff to have accurate information to meet people's needs. Whilst this was positive, there was concern that maintaining reviews and up to date information would be a challenge.

People told us the support they received met their needs.

People and their relatives knew how to raise a concern and many had done so. A positive approach to the management of complaints was in place. However, whilst the number of complaints had reduced, they were still occurring.

Is the service well-led?

Requires Improvement

The service was not always well led.

Action had been taken to address deficiencies in the service since our last inspection. However, there was concern about this being fully embedded and sustained.

A new structure had been introduced to strengthen the management of the agency. A new manager was in post and was in the process of becoming the registered manager.

People felt they were being listened to and communication had improved. Various quality auditing tools had been used to assess, monitor and improve the safety and quality of the service. Some systems required further work to be fully effective.

Mears Help to Live at Home Wiltshire

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 was announced and took place on 3, 4, 11 and 16 December. The inspection was undertaken by two inspectors, a bank inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with 22 people who used the service, 7 relatives and 9 staff on the telephone. We visited five people in their own homes and met with three relatives who were visiting and two members of staff providing care. We spoke with 8 staff in the office, including support staff, care co-ordinators and service managers, the manager and a senior manager. We looked at 9 people's paper and electronic records and documentation in relation to the management of the agency. This included staff supervision, training and recruitment records, quality auditing processes and policies and procedures.

We did not on this occasion request the provider to complete 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 did however, ask the provider for some information such as staff training and recent complaints. This information was provided in a timely manner.

Requires Improvement

Is the service safe?

Our findings

Staff had received recent refresher training in the safe administration of medicines. However, the systems in place were not safe. Support plans did not clearly detail the assistance some people required with their medicines. One relative raised concern that staff often left their parent's medicines out so they could take them later. Due to their poor memory, this practice was not appropriate and the person often forgot to take the medicines or took them at the wrong time. There was no risk assessment or guidance in place for staff to follow in terms of the administration of this person's medicines.

Medicine administration records were not safely completed. Records did not have full instructions about the medicines, their strength, dose or frequency of administration. They were not signed or countersigned by another member of staff to ensure the hand written information was accurate. This increased the risk of error. Staff had not consistently completed the medicine administration record to show the person had taken or declined their medicines. Symbols had been used such as 'O' for 'other' but there was no explanation as to what this meant in practice. Some people had topical creams but there was no guidance for staff to indicate where or how the medicines were to be applied. Not all topical creams were documented as being prescribed by a health care professional. This meant that the safety and appropriateness of the cream was not clear. Some people had medicines to be taken 'as required'. There were no protocols in place to ensure they were used safely and as directed by the prescriber. Within information sent to us before our inspection, management confirmed that there had been six medicine errors within the last three months. These were addressed via the complaints or safeguarding processes.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Newly developed assessments regarding potential environmental risks to people had been completed. However, some only contained very basic information and specific risks to people due to their health care conditions had not been identified. For example, we met two people who were being nursed in bed. There were no assessments to manage their risk of developing pressure ulceration.

Another person told us they could send staff away but this was generally when they were not well. This impacted on the person's wellbeing but an assessment of the risks and how they should be managed were not in place.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Not everyone told us they felt safe. Some people were living with the anxieties which had been caused by previous experiences of the agency. One person told us they still worried whether their carer would turn up or not. Another person said "they don't keep to the same time so you worry they won't arrive." Another person told us they received different carers so did not feel confident or safe in their care. Four relatives of people using the service told us they did not have peace of mind. This was because they felt they needed to be around to ensure their relative's visit took place and also to ensure staff did what was needed. There were many comments about the agency needing to further develop and to maintain improvements before people could feel totally safe. This included the agency ensuring greater consistency of staff, not sending new staff without an introduction and minimising any lateness.

Since our last inspection, improvements had been made to the reliability of the service to enhance peoples' safety. An electronic call monitoring system had been fully installed so that staff logged in and out using their phone, when they arrived and left each person's property. This activity electronically updated the staff member's schedule on the agency's computer systems. If staff did not log in when they arrived at a person's property within a certain timeframe, an alert would be raised in the office. This ensured any missed visits were identified at an early stage and immediately addressed. This early identification, which minimised risk and enhanced people's safety was an improvement to previous practice. Records showed that managers were monitoring the staff's use of the system so that it was being used correctly. This was to ensure all information received was an accurate portrayal of the visits people received.

People using the service, their relatives and staff told us the number of missed calls had reduced significantly since our last inspection. This enhanced people's safety as their required support with personal care, eating, drinking and taking medicines was taking place. However, some missed calls were still occurring. A senior manager confirmed this but said there were now clear, identified reasons for any

Requires Improvement

Is the service safe?

missed calls and they were being identified at an early stage, before any risk of harm. They said there were two missed calls last week. One was due to a fatal road accident where the road was closed and the second, involved a carer who had become unwell on their round. A replacement carer was found but the delay meant that the person had managed their care already so it was classed as a missed call. The senior manager told us any missed calls were fully investigated and reported to safeguarding and the local authority to ensure transparency. They said that improved, more effective systems and additional recruited staff were contributing to a targeted approach of further reducing the occurrence of missed calls.

Staff had received up to date refresher training in safeguarding people. They said they would report any poor practice or abuse they suspected or witnessed, to the office or directly to their line manager. Staff told us they knew about the agency's whistle blowing procedure and there was a copy in their staff handbook. The handbook contained further detail about what constituted abuse and how this should be reported. One member of staff told us a flowchart about how to make a safeguarding referral would be useful, to enable clarity.

Some staff said they had raised concerns in the past in relation to missed calls and inadequate care, given by some staff at previous visits. Staff told us they felt a responsibility towards people and had no hesitation in speaking out on their behalf. Staff told us they felt their concerns were now being listened to more effectively, ensuring greater safety. Up until recently, a high number of safeguarding referrals had been raised by us and other health and social care professionals. The number and serious nature of some of the alerts meant that individual investigations and a whole agency safeguarding investigation were undertaken. These have now been closed and the safeguarding team are satisfied with the progress the agency has made, to address the issues identified.

Management were undertaking a review of all personnel files and the recruitment processes. Some historical issues such as missing references had been found. A senior manager told us that this was being addressed by assessing the staff member's performance and documenting a short summary of this, on their file. A separate team had been set up to manage the recruitment of all new staff. Records showed that a robust recruitment procedure was being followed. Some staff raised concerns that vacant positions were being filled without being advertised. Senior managers explained this was not the case. There was an advertisement of certain positions on the notice board in the office's hallway.

We received varying views about whether there were sufficient numbers of suitable staff to keep people safe and meet their needs. Some people said there were enough staff, particularly when the organisation of visits enabled staff to routinely visit people. Other people told us they believed more staff would be beneficial, as it would minimise any lateness and provide greater consistency at weekends.

Staff were positive about the number of visits they were expected to undertake and said their workload was manageable. One member of staff told us they would inform their supervisor immediately if their visits looked unreasonable. Some staff told us they had little work due to the restriction of new care packages. They were therefore looking forward to the restriction being lifted. Other staff were hesitant in confirming there would be sufficient staff to undertake the increased workload. This caused them some anxiety, especially if the new packages were all in a certain area, at a certain time. Senior managers told us there was capacity to cover the work but they were hoping a coordinated, planned and phased return to full operation would be adopted. This would minimise the risk of overload and a repeat of previous experiences.

Requires Improvement

Is the service effective?

Our findings

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are an amendment to the Mental Capacity Act 2005, which allow the use of restraint or restrictions but only if they are in the person's best interest. Staff were aware of encouraging people to be involved with making day to day choices and decisions. However, staff's knowledge about mental capacity was limited. Most of the staff could not recall having any training about the Mental Capacity Act. This training was not detailed in any records or on the staff training plan. A senior manager told us that they understood the Mental Capacity Act and DoLS were discussed during the mandatory safeguarding training. However, based on our feedback, they said they would re-visit this and ensure additional training was undertaken.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our last and previous inspection, staff had received limited training to support them to do their job effectively. In response to this, focused attention was given to provide staff with refresher training in safeguarding, manual handling, infection control and the safe handling of medicines. Certificates located on personnel files demonstrated this training had been undertaken. The information had also been updated electronically, which meant that an alert would be raised when any future refresher training was required. Records showed that some staff had completed questionnaires as part of their learning. Not all questionnaires were marked. This meant that any shortfalls in staff's knowledge would not be readily identified and could lead to poor practice.

Staff views about the training available to them were positive. One member of staff told us they had recently completed a National Vocational Qualification (NVQ) level two in Health and Social Care. They said they had also completed various other courses since their employment with the agency. Another member of staff said they had been given complaints training as they had recently been dealing with a high number of complaints. Some staff told us they had undertaken training in dementia care and the administration of eye drops. Another member of staff member confirmed the agency's training was much better than their previous employer.

Staff told us the agency was responsive to requests for training. Records showed that some staff had requested training in subjects such as dementia and stoma care. The information did not confirm whether the training had been provided or undertaken. The manager confirmed that any requests from staff would be arranged if relevant and applicable to the people they supported.

Whilst all staff had completed their mandatory training, limited focus had been given to people's needs and their health conditions. A relative confirmed that specific training including mental health and learning disability was lacking. A senior manager told us that gaps in the training programme had been identified. They showed us a training plan, which was in the process of development, to be operational next year. This included training sessions in health conditions such as Parkinson's disease, Stroke, Epilepsy and Multiple Sclerosis.

Staff told us as things were settling down, they felt more supported in their role. They said they felt they were being listened to and were being offered advice, when requested, which was an improvement on their previous experiences. Staff told us communication systems had improved and they were being informed of people's needs before visiting. They said people now had care plans in place, which they could read to gain further information about people when required. One member of staff told us they would contact the person's usual carer, if they had any doubt or queries. Staff told us they rarely visited people they did not know, without any information. They said this was much improved, as previously, it had been a real issue.

New staff told us they felt well supported. They said they undertook a series of training courses and shadowed more experienced members of staff during visits. The agency confirmed that all new staff were expected to undertake a four day pre-employment assessment workshop before being asked to complete at least five supervised shifts in the community.

Some staff told us they had received formal supervision where they could discuss any work issues with their supervisor on a more structured basis. They said this had been beneficial to their morale and their overall work. There was some concern that the system needed to be fully embedded and would require dedicated time to succeed. There was also concern that the system was not consistently available to all staff such as those within the office. One member of staff commented that having the

Is the service effective?

same supervisor at each supervision session was required to ensure honesty and open discussion. The manager confirmed that due to trying to ensure all staff were supervised, there had been inconsistency with supervisors. They said it was anticipated that this would settle and consistency would get better. There were records of staff supervision within personnel files. Whilst the records gave detail to demonstrate what issues had been discussed, action plans were limited. This meant that it was not clear whether issues had been addressed or if they remained outstanding.

People, their relatives and staff told us the service was improving. The majority of people told us consistency of staff was better although they still received some staff they did not know well. Some people said they had a small team of staff which worked well. Others had familiar staff in the week but different, more unknown staff particularly at weekends. Those people who were allocated consistent support were much more positive about their care. Specific comments included "X's lovely. She knows me well and knows just how I like things done" and "I'm very fond of X. I look forward to her coming. She's very experienced and efficient." One relative told us "some staff are very gifted with an attitude you can't teach. Overall, I'm very happy with how things are going". Other comments were "It's much better now, I am at last starting to see regular carers it was awful before" and "we get a regular girl now and it's made so much difference. We know her well and she knows how we like things to be done. It has been a nightmare". More negatively, there were comments such as "unless you get the same staff all the time, they don't really know you. How can they?", "in the last 2 weeks I've had 11 different carers and have asked them not to send one particular carer" and "you regularly need to tell them what to do. They get it and then there's another new one, so you start all over again."

Staff assisted some people with meal preparation and assistance to eat and drink. People told us they either told staff what they wanted or staff offered alternatives, which they could choose from. People told us they generally had snack foods such as soup, eggs or something on toast or a re-heated microwaved meal. Some people told us staff prepared sandwiches which they could eat later in the day. One relative told us that they thought staff could at times, offer greater variety and be more creative in things such as sandwich fillers. They were concerned that not all staff left their parent drinks, which were accessible for later in the day.

Whilst people were generally happy with the food staff provided, there were some comments about the timing of the meal time visits. People said this had improved significantly but there were occasions when a person had a late morning call and then an early lunch call. This meant that both meals would have been close together which was not appropriate.

There were various views about the competency of staff and comments such as "some are better than others". One person told us "some staff are very good but others, well they just stand there. They haven't got the commitment or know what they're doing". A relative told us "It's hit and miss. Some are fine and some aren't. There doesn't seem to be consistency across the board, they're not all as professional as they should be like not putting things away properly and checking they've done it all properly. There's inconsistency of ability, it should all be standard but it's not".

Staff were clear about what to do in an emergency. This included not being able to gain entry into a property or finding a person had fallen. They said they would have no hesitation in calling the emergency services and waiting until help had arrived. Staff told us would notify the office and they would either inform people of possible delays or find a replacement staff member to complete the visits. This said this minimised disruption for people.

People and their relatives told us that staff were very good at recognising particular issues such as dry or sore areas of skin. One relative said "I rely on them to tell me if I need to get the doctor or the district nurse. They're very good like that."

Good

Is the service caring?

Our findings

People and their relatives gave us varying views about the staff. The majority were positive and described staff as kind, respectful, caring, and helpful. One person told us "I like X, I wish I could have her all the time. We have a laugh and she treats me like a person. We get on well." Another person said "there are a few who are exceptional. Very, skilled and experienced. They have a natural ease which gives you confidence." Other positive comments were "I'm very lucky now. I have about three main carers and we get on well. They're all very nice and obliging and will help me however they can" and "they're lovely, like friends to me. We have a laugh. They're all different but they're all good. The system seems to be working well now". Another person said "I'm very happy with them. It took a lot for me to accept strangers into my home but they understand me now and know my moods and where things are. They really cheer me up and I can't wait for them to come". A relative told us "I like the way they talk about anything, as it eases the atmosphere. They always ensure X is comfortable before they go. They're very good and they have an eye for detail, particularly the female staff."

Other comments received from people and their relatives were not so positive. One person told us "I'm mainly happy with the carers but there's one or two, I don't like, I can't explain why I just don't like their personality and I'm not keen on them." Another person said "sometimes they forget they're dealing with people and they don't talk or try to make conversation. Sometimes it feels like they're just getting the job done, they rush and then leave. It doesn't feel right." A relative told us "some they have sent, well, what can I say, I told the office and they haven't come again." Another relative said "It's a shame because there are some good nice carers with a professional caring attitude but it's just not all of them".

We met with one person whilst they were receiving their lunch time visit. Two members of staff and the person's relative were also present. The person had received their personal care and was being assisted to eat their lunch. Staff supported the person in a gentle and attentive manner. They sat next to the person, gave them time and made conversation. Staff asked the person if they were enjoying their meal. The atmosphere was light-hearted and there was banter which the person responded to well. Staff involved the person's relative and encouraged them to be honest when talking to us. They offered to leave the room so the person and their relative could have private, uninterrupted time with us. On leaving, the staff asked if there was anything else which the person wanted or needed to be done. They then told the person "we'll see you later, ok?" The person smiled and said "ok".

Staff had an understanding of person centred care and aimed to provide this. One staff member told us they provided care, which was centred around the person. They said the care had to be beneficial to the person and based on what they wanted and needed. Another staff member said the person "must always come first and be supported to be as independent as possible". A number of staff told us they treated people in a way, which they expected to be treated. Staff told us the improvements which had recently been made, particularly around consistency of visits, had enabled better care to be provided. One member of staff told us "when you know the person you are supporting, it is so much easier, as you know the small details of what makes them happy". Another staff member said "you get to know people and that's good. You don't need to keep asking as you know what they like and how they like things done."

Staff told us how they tried to involve people in their care. They said they would ask the person what they wanted done or if people needed assistance rather than presuming. One staff member told us "You have to go with how people feel on the day. Just because they might want something one day it doesn't mean it'll be the same every day. I ask people how I can help and say "shall we go into the bathroom?" rather than telling people what to do". Another member of staff told us "we might ask the person "shall we make a cup of tea?" rather than making it for them. It's important people are enabled rather than us doing it for them".

The majority of people told us their privacy and dignity was maintained. They said staff always asked if they could draw curtains or close doors when providing personal care. One person told us they did not want their curtains drawn and staff respected this. People confirmed that staff were respectful of their home and did not go into other rooms unnecessarily. One person said "they stay with me but might ask if they can get my breakfast while I finish off getting dressed. They're very good like that. They ask your permission." Another person told us "the staff are always really good when I have a shower. They always let me do

Good

Is the service caring?

the bits I can and my private area. They keep chatting so you forget. It's not an easy situation". Another person told us staff ensured they were covered when undertaking personal care. They said "the staff are very sensitive. You'd think you'd hate it but its ok". Two people told us the agency did not promote their dignity as they regularly had new carers who they had not met before. One person said "how can that promote your dignity. They expect you to strip off in front of someone you don't know to have a shower. I don't think so. I tell them to go away." Another person said "your dignity isn't promoted if you have to keep telling them what you need. They should know."

Staff told us they believed people's privacy and dignity was promoted and well maintained. They said they always used people's preferred names, spoke in a friendly and respectful manner and tried to put people at ease. Staff told us they would ensure curtains and doors were closed when providing personal care. In addition they would respect and be conscious of other people in the house, at the time. One member of staff told us they always ensured the person was covered when assisting them with washing. They said they always thought about how they would feel if they needed to be assisted in an intimate way, by a stranger or someone they did not know well. Another staff member told us it was important for people to be comfortable with their personal care and the support that was given.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, people did not consistently have up to date care plans. This impacted on staff being able to provide support, which was responsive to people's individual needs. Significant work had been undertaken to address this. Within information sent to us before our inspection, management confirmed that over the past three months, each person had received a full review of their care and support services. Where further changes had been reported after the review, management said that staff had revisited to undertake a reassessment and update documentation.

Managers and staff told us a team of staff were allocated the task of meeting with people to discuss their needs and the support they required. They confirmed in response to discussions, assessments and care plans were developed. These were signed by the person, their relative and placing authority if appropriate. Copies of care plans were now orderly stored in filing cabinets in the office. This enabled staff to have access to information as required. People also had an up to date copy of their care plan in their home. Some people and their relatives told us they would sometimes look at the documentation to ensure it was accurate. One relative told us a while back, they were not happy with what was written. They said they addressed this by informing the office and amendments were made. People told us staff documented a summary of each visit before they left their property. They said this was an accurate reflection of what was undertaken. However, whilst the development of care plans was viewed as positive, some people felt it was just a tick box exercise. There was concern that regular reviews would not continue when the pressure of compliance and having to make improvements, lessened. People, their relatives and staff told us that time was required to ensure newly developed systems were embedded. There was some concern about the success of this.

People told us the support they received met their needs. One person told us "it does what it says. It helps me to live at home." Another person said "I rely very heavily on the agency, without it I wouldn't manage." People told us the timings of their visits had improved and if staff were going to be late, they were generally informed. They said "they're more or less on time now" and "generally, they're on time. There's the occasion they're a bit later but it's not excessive." However, some people continued to raise concerns stating that they were not sure what time staff would arrive. One person said "one day they turn up at 7o'clock, the next day it's not until 9. It's difficult as you don't know where you are". Another person told us "sometimes the timings can be a challenge. We're given a time but it's not always the time they arrive." The person continued to say "I can see there are sometimes problems with traffic or someone might be ill but sometimes staff have different times than I do." Another person said "getting your breakfast call at 10.45 is not helpful. Sometimes, I've done it myself so it's not worth having them." One relative told us "they've no idea of whether they're coming or going. They can be 1hr 20 minutes late or early you never know. I've spoken to them time and time again about it".

Staff told us better organisation of visits meant that they were not travelling unnecessarily and were late on fewer occasions than previously. They said they were beginning to be allocated people they knew in a particular area, which increased consistency of care. Staff said they enjoyed supporting people they knew, as they could also identify any deteriorating health or issues which were 'out of character'. The manager confirmed that the scheduling of visits was being undertaken in clusters within postcode areas to minimise additional travelling. They said visits were now being scheduled approximately two weeks ahead to ensure consistency. This timescale had significantly improved, as at our last and previous inspection, visits were being allocated on a day to day basis.

There were some comments about people needing extra time for their visits, additional visits or additional support in areas such as medicines so that a relative could be relieved of the responsibility. One person told us the agency needed to clarify what housekeeping meant. This was because they had asked a member of staff to fold some sheets but the request was refused. The person said they were told that staff were not allowed to do housekeeping tasks. We spoke to a senior manager about these specific issues. They said staff were only able to provide support which the local authority had commissioned, so support with medicines or housekeeping may not have been included in the person's care package. Similarly, the agency was not able to provide

Requires Improvement

Is the service responsive?

additional support or extra visits unless given authorisation by the commissioning team to do so. Following our discussions, the senior manager agreed to follow up an area of particular risk with the commissioning team.

Staff told us that receiving information about people before they supported them had improved. They said they rarely had to provide care without knowing anything about the person. One member of staff said that they found information about the person's needs by talking to them and reading the care plan. Another member of staff said they were given information over the phone by their line manager and they read the care plan. One staff member told us "as well as the agency, it's also our responsibility to find out about people. I would read up about them but if I didn't have time to do that, I'd call their usual carer and find out what I needed to know". Before our inspection, management confirmed that some information was given to staff about people via their phone device. Additional information was provided when confirming the visit with the staff member.

One person told us the agency had assisted them with getting the equipment they required. They said staff were confident and competent in using the hoist to move them safely from one place to another. A relative told us most staff had "got the knack" of ensuring the hoist sling was in the right position to enable full support. They said "only occasionally, X goes lopsided in it". They're usually very good." The person confirmed that this was not a problem and they felt secure whilst being moved. They confirmed that staff informed them about what was happening and involved them as much as possible in the manoeuvres.

People and their relatives told us they would and had called the office if they were unhappy about any aspect of the service. Since the last inspection, complaints had been documented in a more organised manner. People were given an apology and an open approach and full investigation of the complaint was evident. Records showed whether the complaint had been upheld and what actions were to be taken to minimise further occurrences. Whilst the manager told us the agency had improved its recording of complaints, a high number of complaints were still being made. Issues generally involved poor care or staff attitude. People told us that if they complained about a particular staff member, they were not sent to them again. However, there was concern that managers had not asked for further information about the shortfalls. Within information provided to us before our inspection, management confirmed that a total of 41 complaints had been made in the last three months. This number was reducing with seven complaints made in November 2014, compared to 17 in August 2014.

Requires Improvement

Is the service well-led?

Our findings

The aims and objectives of the agency were clearly stated in the staff handbook. However, staff were not able to tell us in detail about these. Some staff told us they aimed to provide "good quality care." Other comments were that the ethos was "client based" and about "promoting independence, privacy, dignity and individuality". One member of staff told us the agency was "very caring" and they "looked after their staff". Another staff member did not agree and said the agency was business orientated.

The majority of people, relatives and staff confirmed there had been improvements in the service since our last inspection. Comments included "it's settling down, things are much better", "we're getting there, it's much less stressful" and "it's getting sorted." There were further comments which indicated people felt they were being listened to and supported to give their views. There was improved confidence that issues raised would be satisfactorily addressed.

Whilst there were many positive views, some people and their relatives felt more improvements were still needed. There were comments such as "they're not there yet", "they have a way to go" and "we still have to be ringing up over certain things". Many relatives and staff told us that they were worried the improvements would not be sustained. This particularly applied to when the seconded managers left or when our involvement as a regulator was reduced. Some people were concerned about the impact of when the restriction to take new care packages was lifted. There was concern that the service would revert back to how it was, which people described as "shambolic", "shocking" and "chaotic". People had high expectations of the new manager and newly appointed senior manager to ensure continual improvement of the service.

Managers told us they recognised that the last few months had been stressful and traumatic for all concerned. They were aware that people were living with the anxieties of their previous experiences and these would need to heal through time, sustained improvement and a re-build of trust. In addition, improved management systems such as scheduling visits, developing care plans and supervising staff were in their infancy. All had to be maintained and embedded to ensure continual improvement and success. The timing of this inspection did not enable this to be evidenced.

Senior managers were aware of people's concerns about the service reverting back to its previous disarray. They told us the lifting of the restriction to accept new care packages had been given careful consideration. Capacity had been assessed and a phased return to business as usual was planned. This was to ensure overload and additional stress to staff and the systems were carefully managed to maintain an effective service. A senior manager told us they anticipated an additional 250 new care hours a week would ensure a smooth transition to business as usual. Following the inspection we met with the senior management of Mears and Wiltshire County Council, who commission services at Mears, to discuss these concerns and ensure that new care packages are commenced in a planned and systematic way. We have asked the provider to send us regular updates on the number of late or missed visits. We will continue to monitor the information we receive.

Within information sent to us before our inspection, it was stated that Mears had recently significantly strengthened the permanent management team and had implemented a new structure. A Director level appointment with sole responsibility for the Wiltshire branch had been made. Three service managers were to support the registered manager.

A new manager who was responsible for the day to day operation of the agency had been appointed. At the time of this inspection, they had been in post for approximately two months and were in the process of applying to become the registered manager. The new manager told us they aware of the challenges which the agency faced, when they applied for their position. They said they had received good support from senior managers and were made aware of the action plans in place to address all identified shortfalls. The manager told us the staff team had worked hard, in difficult and stressful conditions to ensure improvements were made. They said the agency was now "in a better place" and they were confident the service would "go from strength to strength". The manager confirmed that the managers seconded to the agency from within the organisation to support improvements, had fulfilled their remit. They said the agency was now stable and did not require this support although it would be further available if required.

The atmosphere of the office indicated improvements had been made to the service. The environment was calm, relaxed and staff were attentively answering phones when

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they rang. This was in contrast to previous inspections when there were high levels of calls, one after another. A senior manager told us incoming calls had reduced but they were now being monitored. This enabled the number of calls and the staff's response times to be factual for auditing purposes.

Since our last inspection, systems to improve communication had been improved upon. Staff meetings and handovers had been formalised. Managers were electronically sent a copy of each handover so issues could be monitored and further addressed if required. A senior manager told us they were in the process of setting up a new e mail address so that staff could directly raise any concerns they had with them. They said they had met with staff so previous experiences could be "off loaded" giving the ability to move on and embrace new developments.

Managers had met with people and their relatives to discuss concerns and to ensure all information, such as care plans, was up to date. 'Service user' forums and 'service user' community engagement meetings had been arranged. This was to enable people the opportunity to discuss experiences and to suggest improvements in a relaxed, social setting with accompanying refreshments. In addition to the agency's consultation processes, a senior manager told us that the local authority had undertaken their own monitoring. This meant that people and their relatives were able to raise their views within varying forums.

People told us they now felt they were being heard and issues were being addressed. However, many actions needed greater time to be embedded and to be successful. For example, people told us they now received a printed schedule for their week's visits. This was described as a real improvement, as it enabled people to know who would be visiting and at what time. Some people were positive about this development and made comments such as "it's really helpful as you know who's coming to your door" and "it's usually about right". Others raised some concerns saying that the schedule often arrived late and was not fully completed, with terms such as "unallocated" on it. One person said sometimes different staff arrived than those stated on the schedule and often the time of arrival did not correspond. Another person told us "it's only a paper exercise and it changes all the time".

Other systems required further work to ensure full efficiency. For example, the electronic monitoring system was being used to evidence that each person's visit had taken place. It was not being used to monitor the time of the staff member's arrival and departure. Within one electronic record, it showed that a staff member had only spent a few minutes at a person's property. "Unmatched" was stated which indicted a possible issue but there was no explanation or evidence of any investigation. Similarly, within a personnel file, records showed that a member of staff had made an error with a person's medicines. This was shortly after receiving training in medicine administration. There was no evidence of an investigation into the error. A member of staff told us an observation of the staff member's practice would have been undertaken. Records showed this observational visit had taken place but it did not mention that medicine administration had been assessed. There was no evidence to indicate that the staff member's competency was assured. The manager told us a specific process to manage medicine errors had been introduced. This was intended to ensure more focused recording and management of errors, which in turn would enable better trend analysis.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not always receiving their medicines as prescribed and errors were occurring. Full details of medicines and their prescription were not clearly stated on the medicine administration records. Staff were not consistently signing the records to evidence the medicines had been given. There were no protocols to ensure medicines to be taken 'as required' were administered in accordance with the prescriber's instruction. These shortfalls increased the risk of error and did not ensure people received their medicines safely.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Assessments did not identify specific risks to people in terms of their health care conditions. This included the risk of pressure ulceration and the impact of refusing care. There was no information to inform staff how to manage the risks, which did not ensure people's safety.

Regulated activity	Regulation
Personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Staff's knowledge of the Mental Capacity Act 2005 and the implications of this within their practice was limited. This placed people at risk of being deprived of their liberties and indicated that the training they had received was not effective.