Mears Care Limited

Mears Care Torbay and Devon

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Mears Care Torbay and Devon is registered with the Care Quality Commission (CQC) to provide personal care to people living in their own homes. It provides a service to adults with a range of health and social care needs.

On 17 September 2018 the service took over the care visits of an agency that had closed down, this equated to 156 people having care visits. Prior to the transfer, Mears Care Ltd worked with Devon County Council and the provider of the agency that was closing, on a transition plan to ensure safe transfer.

At the time of the inspection and again following the inspection, we asked senior management how many people they now supported with personal care and how many care visits they carried out a week, including those people from the new contract. We did not receive this information.

There was no registered manager in post; however, the operations manager had made an application to register with us but this was withdrawn on 13 September 2018. 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 service had been inspected on three previous occasions. In October 2016, the service was rated 'Inadequate' in all five key questions. We identified eight breaches of the Health and Social Care Act 2008 and associated regulations. The Care Quality Commission (CQC) took enforcement action against Mears Care Limited and imposed a condition on the provider's registration.

We inspected this service again in June 2017 when we found improvements had been made. No breaches of the Health and Social Care Act 2008 Regulations were identified, and the service was removed from special measures. During this inspection we rated the service 'Requires Improvement' overall as improvements were still needed to protect the rights of people who lacked the mental capacity to consent to care and treatment as well as to the service's quality monitoring systems.

The service was last inspected between October and December 2017 in response to concerns raised that the service was not able to provide care visits to people as planned. The service was rated as 'Requires Improvement'. We identified one breach of the Health and Social Care Regulations (Regulated Activities) 2014 and made one recommendation for improvement.

On Monday 24 September 2018 we received information of concern from two relatives and one member of staff that a significant number of people were not receiving care visits as planned. We were also made aware that the local authority, Devon County Council, had been working with the service in crisis management over the weekend, as there were multiple missed care visits. We undertook this focused inspection on 2 and 4 October 2018 to look into the concerns raised.

At this inspection, we found serious shortfalls in the management of risk, insufficient staffing levels and leadership and governance. The overall rating for this service has deteriorated from 'Requires Improvement' to 'Inadequate' and the service is therefore placed in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

The leadership and management of the service was inadequate. We looked at how the provider had managed the transfer arrangements of the care packages between themselves and the care provider who had ceased business. We found governance systems to ensure smooth transfer between providers, safety and continuity of care and consistency of staff had not been effective in ensuring people received safe care that met their needs.

We found there was a lack of management oversight and the systems and processes in place had not ensured that people received their care visits as planned and this had placed some people at risk of avoidable harm. We found the service's business continuity plan, although instigated, had been ineffective in managing/mitigating risks associated with staffing levels. Concerns from senior staff about insufficient staffing numbers prior to the transfer of care packages, had not been escalated to higher management level at Mears Care Ltd or to the local authority.

People were placed at risk because the provider did not ensure there were enough staff available at all times to deliver planned care. We found the systems and processes followed during the transfer of care packages, were not robust or managed effectively. This meant systems had not identified that a significant number of staff were not transferring to Mears Care Ltd and the provider did not have a robust contingency plan in place. This resulted in 91 missed visits between 17 and 23 September 2018, which placed people at risk of avoidable harm.

People were at risk because the provider had not made every reasonable effort to gather information about potential employees transferring from the other care provider to ensure they were of good character and had the necessary employment checks in place such as police checks.

People did not always receive safe care and support. Some people were left for long periods of time without their basic care needs being met. For example, some people were left in wet beds or soiled pads because they could not get out of bed or to the toilet without help. One person told us that they were in a wet bed from 7am until the carer visited at 2.30pm. They told us they had no breakfast or medicines as they relied on carers to get them out of bed. They told us, "I felt helpless, very unsafe, distressed and vulnerable."

Other people were at risk of not receiving sufficient nutrition and hydration. Some people relied on care staff to prepare their meals and drinks, where care visits were missed people went without food and drink as they were unable to prepare this for themselves.

People were not always protected from the risk of harm. Where people had been identified as needing two staff to support them safely, this was not always being provided due to the reduced staffing levels. This resulted in care that was unsafe, placed the person and staff at risk, and did not meet the person's assessed needs. One person told us they felt unsafe.

People did not always receive their medicines as prescribed. Where visits had been missed or were late, people had not received their medicines which put them at risk of harm. For example, people taking medicines to manage their diabetes or heart conditions. People taking medicines for pain control were

subjected to avoidable pain and discomfort due to missed or late visits.

Arrangements in place to review people's care needs prior to the transfer, had failed to identify that 12 people had not had their needs assessed and did not have a care plan in place. This meant staff had not been provided with sufficient information to meet these people's needs.

People and staff were not always given the information they needed and there was a lack of communication. People and relatives told us they were not kept informed about any changes to their care. We heard of many examples of people phoning the office and not receiving a response. This lack of communication had left people angry, frustrated and extremely anxious as they did not know from one day to the next who was coming or if anyone would turn up. One person said, "No one has called to say sorry or explain why this happened."

Staff we spoke with were passionate about their work and knew changes needed to be made but were extremely upset and frustrated by the organisation and how the transfer had been managed. Staff told us they did not feel listened to and when staff had raised concerns these were not taken seriously, and action was not taken. A relative told us, "Staff have been marvellous, but they have too much work to do. One young carer, who was very apologetic for being so late, broke down in tears."

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

People were not having their needs met safely and were placed at risk because they did not receive their visits as planned.

The provider had not ensured there were sufficient staff to meet people's needs and people experienced missed and late care visits.

People did not always received their medicines as prescribed.

The provider could not be assured people were being supported by staff who were suitable to provide care in people's homes. Employment checks had not carried out on staff transferring to Mears Care Ltd from the previous provider.

Is the service well-led?

Inadequate

The service was not well-led.

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

People continued to receive a poor quality service because issues were not identified and resolved by the operational manager.

People and staff were not always given the information they needed and there was a lack of communication.

Mears Care Torbay and Devon

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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 2 and 4 October 2018 and was carried out by two inspectors. We told the service the day before our visit that we would be coming because we wanted them to produce figures and reports we would need to look at during the inspection.

Before the inspection visit we looked at all the information we held about the service and information that that had been shared with us from the Local Authority. We also looked at the last inspection report and any notifications. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

During the inspection we met the executive director, operational manager, quality assurance manager, brokerage manager, two quality leads, the care lead and the senior co-ordinator. Following the inspection we spoke with the human resources TUPE transfer lead. We were contacted by four care staff who wanted to share their views and experiences. We spoke with three people who used the service and the relatives of three other people on the telephone.

We looked at the care records for five people who used the service and the records used by the provider to monitor care visits, the quality of the service and systems and processes.

Inadequate

Is the service safe?

Our findings

Following our inspection in December 2017 we rated the service Requires Improvement in the Safe key question. At this inspection we found that the service was Inadequate. This was because we found a number of concerns relating to staffing levels which had resulted in missed and late calls. These missed and late calls resulted in significant risk to people's safety and physical and emotional well being. We identified a number of concerns relating to the management of risk including; management and administration of medicines, pressure area care, maintaining adequate nutrition and hydration, moving and handling, skin integrity and personal care.

People were placed at risk because the provider did not ensure there were enough staff available at all times to deliver planned care. This resulted in people being exposed to risk and subjected to significant harm. During the transfer of care from the closing service which took place over a number of weeks, the management team did not review people's care plans or risk assessments to see if they were accurate and reflected their needs. This meant the provider had failed to identify at the time of the transfer, 12 people did not have a care plan in place.

The failure to identify and meet people's needs led to multiple incidents of concern and 17 individual safeguarding alerts were made to the local authority.

People did not always receive safe care and support. Some people relied on staff to meet all of their physical and personal hygiene needs including helping them to get out of bed, wash and dress or use the toilet. Some people were left for long periods of time without their basic care needs met. For example, one person was left in their wet bed for 17 hours on one day and 12 hours on another day. This put the person at significant risk of skin damage. Their relative told us they were unable to help them out of bed and this caused them and their relative extreme distress and anxiety. They told us, "We don't know from one day to next who is or if anyone is coming." Another person told us that they were in a wet bed from 7am until the carer visited at 2.30pm. They told us they had no breakfast or medicines as they relied on carers to get them out of bed. They told us, "I felt helpless, very unsafe, distressed and vulnerable."

Another person's relative told us their mother had not received their teatime visit which meant they had been unable to use the toilet as they were not able to get out of bed by themselves. This resulted in the person being incontinent of faeces which was only discovered and acted upon, when the care staff visited them in the evening. This meant the person was placed at increased risk of skin breakdown and this had a significant negative effect on the person's dignity and well being.

People were at risk of not receiving sufficient nutrition and hydration. For example, one person's care plan identified they were at significant risk of weight loss. The person had previously been admitted to hospital due to insufficient food and fluid intake. The person was unable to prepare and cook their own meals and drinks and relied on care staff to do this for them. On 23 September 2018 records showed that they did not receive their care visits scheduled at breakfast or teatime. This meant they were not provided with sufficient amounts to eat and drink putting them at risk of malnutrition and dehydration. One relative of another

person who relied on care staff to meet their nutritional needs told us, "I don't believe my mother is safe. She has been put at risk as staff have not visited or ensured that there is food and drink in the house and she has something to eat and drink. This whole situation has caused so much distress and I feel so guilty as I do not live locally."

People were not always protected from the risk of harm. Where people had been identified as needing two staff to support them safely, this was not always being provided due to the reduced staffing levels. We found some people assessed as needing two staff members to assist them with personal care and mobility, received visits by one member staff only. Records from 17 to 23 September 2018 showed that five people requiring two staff to support them at each visit, experienced missed visits where no staff arrived to give care. This meant these people did not have their needs met in relation to personal hygiene, skin care, continence and nutrition and hydration. People told us they felt unsafe. For example, one person who required two staff to hoist them into bed, slept in their chair overnight as they did not feel safe to be hoisted back to bed by one staff member only. This resulted in care that was unsafe, placed the person and staff at risk, and did not meet the person's assessed needs.

People did not always receive their medicines as prescribed. Where visits had been missed or were late, people had not received their medicines which put them at risk of harm. For example, one person required staff to administer their medicines first thing in the morning to manage their diabetes. Their care plan informed staff this medication was essential because it supports them with to manage their diabetes. This person had previously been admitted to hospital because his medications were not being taken as prescribed. Records showed the person did not receive their morning care visits on 22 and 23 September 2018 and therefore did not receive their medicines. This put them at significant risk harm from diabetes complications and life-threatening conditions. Another person required staff to administer time specific medicines for their heart, to be taken in the morning between 9.30am and 10am. However, on 20 and 22 September staff did not visit until between 12pm and 12.30pm. They did not receive any visits on 21, 23 and 24 September. This meant they either did not receive their essential heart medicines or they received them late, which placed them at risk of harm.

Some people taking medicines for pain control were subjected to avoidable pain and discomfort. For example, one person did not receive their Oramorph, a strong opioid pain medicine, during their evening visit as the care worker visiting was unable to administer medicines. Another person did not have their pain relieving medicine patch changed because their care visits had been missed on 22 and 23 September.

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

Prior to this inspection, we received information of concern from two relatives and one member of staff that a significant number of people were not receiving care visits as planned. We were also informed the local authority, Devon County Council, had stepped into the service to provide crisis management support when multiple missed care visits had been alerted to them. During the inspection we found the service was unable to provide care to a number of people due to insufficient numbers of staff. We found the systems and processes followed during the transfer of care packages, were not robust or managed effectively. This meant systems did not identify that a significant number of staff were not transferring to Mears Care Ltd and the provider did not have in place a robust contingency plan. This resulted in 91 missed visits between the 17 and 23 September 2018, which placed people at risk of avoidable harm.

Failure to deploy sufficient numbers staff to meet people's care and treatment needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

People were at risk because the provider had not made every reasonable effort to gather information about potential employees that had transfer from the other care provider to ensure they were of good character. During the transfer of business from the previous care agency. The manager did not ensure that all staff transferring to Mears Care Ltd had the necessary employment checks in place including current Disclosure and Barring Service (DBS) checks prior to working with people who may be vulnerable by their circumstances. Mears Care Ltd human resources TUPE transfer (Transfer of Undertakings Protection of Employment) lead and the executive director of Mears Care Ltd told us they would have expected this to have been done at branch level prior to the transfer taking place. The manager told us this had not been done.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The service was not well led. During the inspection in December 2017 we rated the service Requires Improvement in the Well Led key question. At this inspection in October 2018 we found there was a lack of management oversight and the systems and processes in place had not ensured that people received their care visits as planned and this had placed some people at risk of avoidable harm. We have rated this key question as Inadequate.

At the time of the inspection there was no registered manager in post; however the operations manager had made an application to registered with us. 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.

We carried out this focused inspection following concerns received from two relatives, one staff member and the local authority about missed and late call visits. We looked at how the provider had managed the transfer arrangements of a large number of care packages between themselves and a care provider who had ceased business. We found governance systems to ensure smooth transfer between providers, safety and continuity of care and consistency of staff had not been effective in ensuring people received safe, effective, responsive care that met their needs.

There was a management structure in the service which provided clear lines of responsibility and accountability. The operations manager was supported by a team of senior staff with specific management responsibilities: reviewing people's care needs; quality monitoring, including complaints management; visit planning; staff recruitment and training, and staff performance reviews, supervision and appraisal. However, we found there was insufficient management oversight to ensure people received the care and support they needed in a way that promoted their well being and protected them from harm. This had resulted in 91 missed visits and a significant proportion of people receiving visits that were late between the 17 and 23 September 2018.

Due to the lack of management oversight, the local council, Devon County Council, stepped into the service to provide management support. The local community nurse team and the local authority's rehabilitation team assisted to provide essential care visits. Devon County Council told us some people had to be admitted to residential care as people could not be assured their care needs would be met by Mears Care Ltd under the current circumstances. Devon County Council continues to provide management support to the service.

There was a lack of oversight by senior managers to ensure that appropriate action was taken where they had identified people were placed at risk. For example, during the TUPE transfer (Transfer of Undertakings Protection of Employment) process senior staff identified a significant amount of staff were not transferring to Mears Care Ltd. Senior staff told us they knew prior to the transfer date that they did not have sufficient numbers of staff to meet people's assessed needs in a safe way. They told us they had escalated their

concerns to the operations manager. We discussed what we had been told with the operations manager and asked them what action they had taken. The operations manager told us they were not aware of exactly how many staff were not transferring, the care hours this equated to and the impact this would have. The operations manager told us that if they had been aware of this they would have escalated their concerns to their line manager and the local authority. They fully acknowledged that the transfer arrangements had not been managed well.

We found the systems and processes followed during the TUPE transfer, were not robust or managed effectively. This meant they did not identify that a significant number of staff were not transferring and the provider did not have in place a robust contingency plan. This resulted in 91 missed visits and a significant proportion of people receiving visits that were late between the 17 and 23 September 2018.

Although the provider had a recruitment policy in place the operations manager had not ensured checks were undertaken that staff transferring between providers throughout the TUPE process, had been recruited safely. For example, on the day of the inspection senior managers were unable to assure themselves that staff currently supporting people in their homes had current DBS and were suitable to be working with people that were vulnerable due to their circumstances. Following the inspection we received confirmation these checks had been completed.

Although arrangements were in place to review people's care needs prior to the transfer, these had failed to identify that 25 people had not had their needs assessed and did not have a care plan in place. This meant staff had not been provided with sufficient information to meet people's needs.

People were not always protected from the risk of harm as the systems in place to manage and mitigate risks were not effective. The service had a business continuity plan. This highlighted events that might cause disruption to the service and outlined actions staff should take in response such as prioritising visits to those most in need and negotiating with family members to care for others. The service had undertaken a risk assessment of which people were most dependent on care visits for their safety and wellbeing. This meant the service could prioritise providing care to those people in the event of staff sickness, bad weather or other emergencies. The quality assurance team told us the continuity plan was also followed for periods when the service suffered staff shortages. Following the transfer we found the business continuity plan had been ineffective in managing/mitigating risks associated with staffing levels. This was because following a review of people's level of needs it was discovered that 80 percent of people transferred were rated as high need and should therefore have prioritised visits in the event of staff shortages. However, the provider did not have enough staff to meet those needs even though their business continuity plan had been instigated. This led to people being placed at risk and harm.

People, relatives and staff told us the transfer arrangements were not well managed. People and staff were not always given the information they needed and there was a lack of communication. Some people had been visited prior to the transfer by senior staff and reassured that there would be no change to their care provision, for example, time and staff, the only change they would notice would be the different uniform. People and relatives told us they were not kept informed about any changes to their care. We heard of many examples of people phoning the office and not receiving a response. One relative told us, "I've made numerous calls to the office to find out what was happening and when people are going to come. You never seem to speak to the same person and people say they are going to call you back but they never do. We have had to rely on information from staff." This lack of communication had left people angry, frustrated and extremely anxious as they did not know from one day to the next who was coming or if anyone would turn up. Another person said, "No one has called to say sorry or explain why this happened."

Staff we spoke with were passionate about their work and knew changes needed to be made but were extremely upset and frustrated by the organisation and how the transfer had been managed. Staff gave us numerous examples of distressing situations people had been left in because of missed and late visits. Staff told us they did not feel listened to and when staff had raised concerns these were not taken seriously and action was not taken. Staff told us this had impacted on their morale and staff had left the service as they were unhappy. A relative told us, "Staff have been marvellous but they have too much work to do. One young carer, who was very apologetic for being so late, broke down in tears."

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