Mayberry Care Services Limited

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Inspection report

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15 January 2019
16 January 2019
24 January 2019
28 January 2019

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Mayberry Care Services Limited is a domiciliary care service providing personal care to nine people many of whom had complex health care needs at the time of the inspection.

People's experience of using this service:

People were not protected from avoidable harm and known risks were not responded to or mitigated. Shortfalls in the service meant people had been exposed to immediate risk of significant harm. The registered manager had not recognised or acted on safeguarding concerns. Lessons were not learnt when incidents occurred and this placed people at risk of ongoing harm.

The provider had not ensured staff had received training in all people's healthcare needs and as such staff had been providing clinical care tasks without the specific training or oversight. This had put people at serious risk of harm. The provider had not ensured checks were carried out on staff competencies to ensure they were providing safe care. Where concerns about staff practice had been noted through observations of care these had not been addressed by the provider.

People could not be assured that concerns or complaints would be dealt with. There were no robust systems to deal with complaints or for the provider to learn from complaints received. Whilst care plans had been reviewed they had not always involved the person. Care plan reviews had not been effective in identifying where care plans were incomplete.

The provider had not ensured they had robust and effective systems in place to monitor the quality and safety of the service and had failed to recognise the widespread shortfalls in safety. As a result people were exposed to significant levels of harm on an ongoing basis.

More information is in the full report

Rating at last inspection: Good (Report published 1 March 2017)

Why we inspected: We brought the inspection forward due to serious concerns we had received about an unexpected death at the service. Whilst the investigation into the death is on-going we carried out this inspection to check on the safety of the other people receiving care from the service.

Enforcement: As we have rated the service as inadequate, the service will be placed in 'special measures'. Services in special measures will be kept under review. Following the inspection we took urgent action to impose conditions on the providers registration to restrict admissions to the service. In the meantime the provider submitted an application to deregister and we therefore withdrew any further enforcement. At the time of the publication of this report there are no longer any people using the service which is now closed.

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 safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our Effective findings below	**Inadequate**
Is the service caring? The service was not always caring. Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Mayberry Care Services Limited

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of choking. This inspection examined those risks.

Inspection team: The inspection was carried out by one inspector on the 15 and 16 January 2019 and two inspectors on the 24 and 28 January 2019

Service and service type: Mayberry Care Services Limited is a domiciliary care agency. It provides personal care to people living in their own homes in the community.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We gave the service 48 hours' notice of the inspection visit because we needed to ensure someone would be available to assist us with our inspection. We visited the office location on 15, 16, 24 and 28 January 2019 to see the provider, manager and office staff; and to review care records and policies and procedures.

What we did:
Before the inspection we reviewed any notifications we had received from the service. A notification is information about important events which the service is required to tell us about by law. We also reviewed any information about the service that we had received from external agencies. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with three people who used the service and three relatives. We spoke with four staff members, the nurse educator, the quality and training lead, the registered provider and registered manager. We raised our concerns and liaised with the local clinical commissioning groups who funded peoples care. We looked at seven people's care records, training records, complaints and audits and quality assurance reports.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management

● People were not protected from the risk of harm. The provider had failed to ensure that the risks associated with peoples care were reduced and monitored sufficiently and this meant people were exposed to an on-going risk of harm.

• Known risks to people had not been investigated and measures had not been put in place to reduce the level of risk to people. This included risks such as entrapment, moving and handling, pressure sores, catheter care, diabetes, epilepsy and activities that may cause a person harm.
• One person undertook illegal activities that could cause themselves and others harm. There was no detail of this in the persons care plan or risk assessment and subsequently staff did not have guidance on what to do when this activity occurred. The provider had failed to consult other professionals such as the police or safeguarding teams in order to provide safe care to this person.
• Known risks to people were not monitored or responded to sufficiently. We found that action had not been taken to seek medical assistance for one person. Other people needed support to move position at certain time intervals to reduce the risk of sore skin. The provider had not ensured these actions were taken and had failed to identify this as a concern.
• Care records did not contain up to date and accurate information about peoples health conditions and how they were to be supported safely. This placed people at risk of receiving unsafe care as staff did not have sufficient guidance.
• There was insufficient oversight of clinical tasks that staff were undertaking. This potentially exposed people to serious levels of harm as practice was not consistently monitored to ensure it was carried out safely.
• Where risk assessments had been completed there was insufficient detail or consideration of how to reduce the risk to an acceptable level.
• There had been an unexpected death of a person using the service as a result of choking. We found two people had been assessed as at risk of choking. There were little or no risk assessments in place to guide staff in how to reduce the risk of choking occurring or what action to take should this happen. The provider had failed to take timely and sufficient action to learn from this incident and this placed people at continued risk of harm.
• Due to the severity of our concerns about peoples care we made safeguarding referrals to the local authority following our inspection.

The failure to prevent avoidable harm or risk of harm is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

• People were supported by staff who understood the signs of abuse and appropriate action to take should they have concerns. Staff had received safeguarding training and were able to describe the action they would take to report any concerns.
• We found two instances where the registered manager had not taken appropriate action to identify or report safeguarding concerns to the appropriate agencies. This meant people had not been protected from the risk of abuse and improper treatment.

The failure to have robust safeguarding procedures is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
• There were no robust systems to record and learn from incidents that had occurred at the service including behavioural incidents. For example, we found one person had gone missing on a number of occasions for a significant amount of time despite having 24-hour support. No investigation had occurred following these incidents and there was no guidance available to staff of what to do when this occurred. The provider had failed to reduce the risks to people and this placed people at ongoing risk of harm.
• On the third day of the inspection the registered manager provided us with evidence of the new system that would be put in place to enable incidents to be monitored.

The failure to prevent avoidable harm or risk of harm is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
• Staff informed us they had received medication training and that checks were carried out to ensure they were safe to perform this task. Whilst staff had received medication training we found one example of unsafe medication practice that indicated that staff training was not always put into practice. Staff were able to tell us how they would support someone who refused to take their medicines safely.
• We found that consent to change the consistency of a medicine had not been sought from a healthcare professional. The registered manager advised us on day three of the inspection that this was been actioned.

Staffing and recruitment
• People were supported by sufficient numbers of staff. Many people using the service received 24-hour care. Our review of a sample of rotas showed us that people received the correct staffing levels.
• Staff were recruited safely. Checks were carried out to ensure staff were suitable to work with people. We saw that the providers recruitment process included obtaining a Disclosure and Barring Service Check (DBS) to check whether staff were safe to work with people. We found that references weren't consistently validated to ensure they were credible. Doing this would further assure the provider that robust checks had been carried out on the staff members past employment history.

Preventing and controlling infection
• Staff were supplied with gloves and aprons to be used when supporting people. Sufficient supplies of personal protective equipment were checked when spot checks were carried out at peoples homes.
• One person told us that a cleaning rota had been introduced at their home to ensure their living environment was kept clean and tidy.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Staff support: induction, training, skills and experience
• Staff had received insufficient training to meet all peoples complex healthcare needs. In one example we found that staff were supporting one person with a healthcare procedure in which they had not been trained. This placed the person at high level of risk. We advised the registered provider and registered manager to cease providing this care and to source the support of a qualified healthcare to perform this procedure.
• In another example staff had not received training in one persons specific spinal condition. This placed the person at risk as staff may not recognise the signs of deterioration in the persons health.
• Staff were performing complex clinical care tasks such as tracheostomy care and percutaneous endoscopic gastrostomy (PEG) care. PEG is used as a way of receiving nutrition through a tube inserted directly into a persons stomach. We found that staff lacked sufficient oversight and checks were not consistently carried out on staffs competencies to ensure they were performing these tasks safely. This placed people at risk of unsafe care.
• Some observations that had been carried out by the nurse educator who was employed by the service had indicated issues in staff practice. For example, one staff member was observed performing a clinical care task in an unsafe manner. No action had been taken by the registered manager to investigate or follow up these concerns or to provide further training or supervision of the staff member. This had exposed people to ongoing risk of harm.

A failure to ensure staff were suitably qualified, competent and skilled is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
• A number of people were supported to receive nutrition through a PEG tube. We found that care plans for two people stated the amounts of feed to give which related to a different person. This placed people at risk of harm as they may of received an incorrect amount of feed.
• One person was a type two diabetic and would require foods that would be healthy to enable their diabetes to be better controlled. Records showed that this person received inappropriate foods on a number of occasions which placed them at risk of their health deteriorating.
• Another person had been prescribed supplements and needed a specific diet to enable them to maintain their weight. There was no mention of this in their care plan and this put the person at risk of losing weight. This person had also seen a speech and language specialist who had recommended ways to prepare the persons food safely to reduce the risk of choking. The assessment was not available and had not been

incorporated into the care plan. The provider had failed to ensure healthcare professionals assessments were followed by not making the information available to staff and this put the person at risk.
A failure to provide safe care and treatment is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care
• Whilst we saw examples of the service working with other agencies such as the district nurse team and hospital teams we also found that that the provider hadn't recognised when healthcare professionals assessments were needed when people's needs had changed. This had placed people at on-going risk.
• However timely action had not always been taken to seek medical assistance or follow healthcare professionals advice and as such peoples safety had been put at risk.

Adapting service, design, decoration to meet people's needs
• The service had carried out environmental risk assessments around people's homes to identify any risks to people and staff working at the persons home.

Supporting people to live healthier lives, access healthcare services and support
• Some people using the service also had regular input from the district nurse service for certain healthcare tasks. Staff informed us how they communicated with the management of the service of any peoples healthcare changes to ensure the district nurse team could be contacted. Whilst staff informed us that healthcare professionals were contacted we found that this had either not happened or there had been a delay in seeking healthcare support for some people. This had placed people at risk of harm.
• One person we spoke with told us that they received timely healthcare support when they needed it. They told us, "GP would come out to see me. Staff call him first or sometimes a district nurse comes out."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Although the provider informed us they carried out pre- admission assessments of people's needs to determine whether their needs could be met we found that the provider had not always been able to meet people's assessed needs safely.

Ensuring consent to care and treatment in line with law and guidance
• 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. We checked whether the service was working within the principles of the MCA.
• Staff understood the principles of the MCA and explained how they ensured people were offered choice in their care. We found the service was not consistently working in line with the principles of the MCA. People's care plans stated whether they had capacity or not but there was no detail of how this decision was made nor that the assessment should be decision specific. One person had been assessed as having capacity although we noted that consideration had not been given to the possibility of fluctuating capacity due to activities they undertook.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; equality and diversity
• The provider had not ensured people were well treated and supported as they had not ensured known risks to people were minimised or monitored.
• The providers systems did not support the service to be fully caring. For example, people could not be assured concerns raised would be addressed, staff had not had the required training to provide specific care to some people and poor staff practice had not been investigated. This meant people were at risk of ongoing harm.
• Staff informed us they enjoyed supporting people and were committed to their roles. One staff member told us the best part of their job was, "To see that a client is happy. We are there to support them and make them happy."
• One person told us, "I've got good carers at the moment."
• Two people informed us that they didn't get a good continuity of carers. The registered manager provided us with evidence from rotas that people were getting consistent staff.

Supporting people to express their views and be involved in making decisions about their care
• Whilst we found that some people had been supported to be involved in making decisions about their care this was not the case for everyone. There was no consistent evidence that people's care had been reviewed with them.
• One person informed us that they had to inform the management team a couple of days in advance when they wanted to go on an outing outside of the local area. This was despite the person receiving 24 hour care. The registered manager and registered provider explained that some staff wouldn't be comfortable going to some of the places this person wanted to visit but if they had notice then they would be able to provide staff who would be comfortable. This person was not fully supported to receive personalised responsive care.
• Staff informed us about different communication techniques they used to help people to express their views. This included using letter boards to enable people to spell out what they would like.
• One person told us, "The care is good when I'm doing what I want."

Respecting and promoting people's privacy, dignity and independence
• People were supported to have their privacy and dignity respected and independence promoted. Staff informed us how they ensured people retained their privacy and dignity when providing people with personal care. This included closing curtains and doors and seeking peoples consent before supporting them. One staff member talked with us about the care they provided to one person and told us, "We have to respect her choices and respect her dignity."
• One person told us that staff supported their independence and told us, "They [staff] let me do what I can."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Improving care quality in response to complaints or concerns
• People could not be assured that any complaints or concerns raised would be acted on. We found the complaints process was not robust. From a sample of six complaints there were no clear processes to indicate whether the complaint had been investigated or where they had been investigated whether the complainant was satisfied with the response.
• There were no systems in place to ensure complaints were learned from to improve the quality of service provided to all people.
A failure to have robust complaints procedures in place is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Whilst many care plans had been reviewed, these reviews had not been effective in identifying where people's care plans were inaccurate or where people's known risks had not been mitigated. This placed people at exposure to risk of harm as there was insufficient guidance for staff to provide safe care.
• Whilst we were informed that people were involved in reviewing their care there was no clear evidence that people were consistently involved in reviewing their care.
• Staff informed us that there were systems in place to inform them of any changes in people's care needs such as communication books.
• People informed us of holidays, sometimes abroad, that staff had taken them on. The person had stated where they had wanted to go and the service had worked with the person to ensure this happened.
• One person informed us that staff who supported them didn't always have the same interests as them. We spoke with the registered manager who explained that they tried to match staff to people with similar interests but that where this wasn't possible they informed staff of the persons interests so they were aware.
• Staff informed us of the support they were providing to one person to encourage them to access the community more often to aid their well-being.

End of life care and support
• There was no one currently receiving end of life care at the service.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility;
Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager had not ensured they understood their responsibility for safeguarding people who used the service and as such had failed to take action to make safeguarding referrals as appropriate.
- The registered manager and registered provider had failed to ensure that they had an effective governance system in place. We found that monitoring systems were not robust and had failed to ensure people were protected from the risk of harm.
- The provider had failed to have systems in place to identify and minimise risks in peoples care and had not recognised people were exposed to significant levels of risk as a result.
- The provider had not recognised or properly considered what people's care needs or risks were and therefore care plans and risk assessments that were in place were insufficient. Staff did not have appropriate guidance to follow which exposed people to risk of unsafe or inappropriate care practices.
- Monitoring systems in place were not effective and had failed to protect people's health and well-being. For example, changes in people's healthcare needs had not always been highlighted through the providers monitoring checks and therefore there had been delays in seeking medical advice which placed people at significant risk of harm .
- There were no systems in place to ensure staff were providing safe and appropriate care and we identified serious areas of concern around staff practice that had not been addressed. This put people at risk of harm.
- There had been a lack of oversight of staff practice and training had not been provided around all people's needs, particularly in relation to complex healthcare tasks staff were undertaking.

A failure to have robust and effective governance systems in place is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We saw the last inspection report was on display in the offices and on the providers website as required.

- The registered manager had failed to notify the commission of three separate incidents.

A failure to notify the Commission of specific events and incidents is a breach of Regulation 18 of the Health and Social Care 2008 (Registration) Regulations 2009.

Continuous learning and improving care

• At our last inspection in March 2017 we identified that the provider needed to take further action to reduce the risks associated with people's mental health. We found that this had not been fully implemented and there was still a lack of guidance available for staff of action to take should a person refuse support or partake in activities which could cause them harm. The provider had not ensured they learned or acted to improve the care provided to people.

• There were no systems in place to learn from incidents such as behavioural incidents, instances of poor staff practice or complaints to improve the quality of the service. Several serious concerns were identified during our inspection and the provider had not taken action to respond to these issues, placing people at serious risk of harm.

• Spot checks took place to check that people were happy with their care. In addition, these checks were used to observe staff practice. However, we found that these checks had not been effective in identifying the issues we found at the inspection and the serious concerns had not been recognised.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• We saw that a questionnaire had been sent to people, relatives and staff for their views of the service. Whilst the results had been analysed there was no indication of how many people had responded to the questionnaire. In addition, there was no action plan in place to monitor whether suggested improvements had been made or whether they had improved the service for people.

• Staff felt supported in their roles and one staff member told us, "Working for Mayberry is very good." Staff informed us they had team meetings and supervisions which aided their sense of support. However, the provider had not ensured adequate support or training was provided to staff.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager had failed to notify the Commission of incidents as required. 18(1)(2)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had failed to establish robust safeguarding procedures. 13(1)(2)(3)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered provider had failed to establish robust complaints procedures. 16(1)(2)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to mitigate and monitor risks to people and had failed to prevent avoidable harm. 12(1)(2)(a)(b)(c).

The enforcement action we took:

We have taken urgent enforcement action to impose immediate conditions on the registered providers registration in order to protect people's safety and well-being.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to operate effective systems to monitor the safety and quality of the service provided. 17(1)(2)(a)(b)(c)(e)(f).

The enforcement action we took:

We have taken urgent enforcement action to impose immediate conditions on the registered providers registration in order to protect people's safety and well-being.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure staff were appropriately qualified, skilled and competent to provide safe care to people. 18(1)(2)(a)

The enforcement action we took:

We have taken urgent enforcement action to impose immediate conditions on the registered providers registration in order to protect people's safety and well-being.