Sevacare (UK) Limited

Mayfair Homecare - Portsmouth

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was carried out on 24 July 2018. We gave 24 hours' notice of our intention to visit Mayfair Homecare (Portsmouth) to ensure that the people we needed to speak with were available.

Mayfair homecare is a provider of community home care services, supporting 135 people within the Portsmouth area.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act and associated Regulations about how the service is run.

This was Mayfair Homecare's first inspection since registration. We made a recommendation during this inspection that the provider ensure documentation surrounding people's ability to consent to their care in accordance with the Mental Capacity Act 2005 be reviewed.

Documentation relating to people being able to consent to their own care was not always present in care plans. Where people were not able to sign their consent forms due to lack of capacity, Lasting Power of Attorney (LPoA) documentation was not always available in people's care plans even though relatives had signed on the person's behalf. The registered manager agreed to retrieve the correct documentation during our inspection and began to rectify this issue immediately following our discussion.

Medicines were safely managed in accordance with the provider's policy and staff had received training and competency assessments prior to being able to administer medicines to people.

There were enough staff deployed to support people safely and the provider completed robust recruitment checks to ensure the right staff were employed to care for people. Innovative recruitment practices had been implemented to encourage new staff to join the provider workforce.

Infection control practices were followed and staff received training in this area to ensure that people were safe from the spread of infection.

Risk assessments were completed to identify and manage risks to people and staff to keep them safe.

Staff gave good examples of how to recognise the signs of abuse and who to report any concerns to. Staff were aware of the whistleblowing policy and felt confident that any concerns raised would be dealt with effectively.

Lessons learned from incidents were discussed with staff at team meetings to ensure best practice was followed and learning was shared with all staff to prevent reoccurrence.

Staff received an initial induction, training and shadowing opportunities as a new member of the team. The provider offered mandatory, annual refresher training to ensure their staff maintained the appropriate skills and knowledge to carry out their roles effectively. Supervision, spot checks and annual appraisals were provided for staff and staff were offered other training opportunities to develop professionally if they wished. Staff achievements were recognised with an annual awards ceremony.

The service had implemented 'diversity Thursday' where staff were encouraged to embrace different cultures represented within their own teams. This was part of the wider 'Wellbeing Framework' which included tackling loneliness amongst people using services within the community, a 'disability confidence scheme', 'Armed Forces covenant' and subscription to 'The Care Workers Charity.'

People were supported to maintain adequate nutrition and hydration where required and where health or social care support was necessary, this was arranged. The management team had established good working links with the local authority safeguarding and social work teams to ensure that their working relationships were transparent and open.

Care workers and office staff provided compassionate and kind care to people. Fundraising was an ongoing endeavour to provide events for people to tackle loneliness and promote inclusiveness. Dignity and respect for people and improving the quality of lives for service users and their families was a major aspect of the new 'Wellbeing Framework'.

End of life care and support was not only provided to people using the service, but to their families and those who were significant to the person. Care plans for those at the end of their lives were taylor made for the individual and people and their relatives were encouraged to contribute and make decisions that affected the care and support they received.

People received personalised care and support in accordance with their needs and wishes. Care plans were reviewed periodically and adjusted according to people's changing needs. The care plans contained information relating to people's preferences and their social history so as to offer a holistic view of the person.

Complaints were received and dealt with effectively and were reflective of the provider's complaints policy.

People and staff gave positive feedback about the management team. Staff felt able to go to the registered manager with any concerns and they would be listened to.

The service encouraged feedback from people and conducted annual surveys which were sent out from head office and analysed. Any areas of improvement required were then forwarded to the registered manager and regional manager to implement change. The service completed weekly reports and audits to ensure the smooth running of the service and to establish any areas for improvement locally.

The service promoted an open, compassionate culture with people and staff at the centre. Wellbeing was at the forefront of the service and was encouraged and developed by the management team.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

There were enough staff deployed to care for people safely.

Robust recruitment processes were in place to ensure the right staff were employed to care for people. Innovative recruitment practices were in place to encourage staff to the workforce.

Infection control practices were followed.

The service managed medicines safely.

Risks to people's safety and wellbeing were identified, managed and practical measures were in place to keep people and staff safe.

Lessons learned from when incidents occurred was shared with staff to prevent reoccurrence and promote best practice

Is the service effective?

Requires Improvement

The service was not always effective.

Paperwork relating to people's capacity to consent to their care was not always available in care plans.

Staff received an induction and ongoing training, supervision and appraisal to ensure they maintained the required skills and knowledge to carry out their roles effectively.

People were supported to maintain their nutrition and hydration intake when required and to access health and social care services as appropriate.

Is the service caring?

Good

The service was caring

People were supported by compassionate and caring staff who knew them well.

People gave positive feedback about their experiences using the service.

People were encouraged to contribute to decisions about their care and support and to include people who were significant to them in reviews about their care if desired.

The service actively promoted equality and diversity within the service.

People and staff were at the forefront of the new 'Wellbeing Framework' which had been implemented within the service.

People's dignity and privacy was respected.

Fundraising took place to provide activities and events for people using the service.

Is the service responsive?

Good

The service was responsive.

People were treated as individuals and their needs, preferences and choices were taken into consideration when care plans were completed.

Care plan reviews were undertaken as a person's needs changed and at periodic intervals.

People's social history was recorded in care plans so as to look at the person from a holistic perspective.

End of life care was taylor made to the individual and took into account a person's family and other significant people.

Complaints were dealt with effectively and in accordance with the provider policy

Is the service well-led?

Good

The service was well-led.

The management team promoted an open and transparent culture. Staff felt valued within the new 'Wellbeing Framework'.

Staff were provided with opportunities to develop within the organisation.

The service maintained productive working links with the local

authority and other health and social care professionals.

People and staff spoke highly of the registered manager and management team as a whole.

Quality assurance processes were in place to ensure that people using the service were safe and any immediate areas for improvement were identified and acted upon. Although these processes did not detect the lack of LPoA documentation available.

Annual satisfaction surveys were sent to people using the service, feedback was then analysed and disseminated locally for any improvements to be made.

Mayfair Homecare - Portsmouth

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. We looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

This inspection was completed in one day by one Inspector.

Prior to the inspection we looked at the information we had collected about the service. This included information received from members of the public and external healthcare professionals and notifications the registered manager had sent us. A notification is information about important events which the service is required to tell us about by law. The provider had submitted a Provider Information Return (PIR); this provides the Commission with some key information about the service and how it is run.

During the inspection we spoke with nine people using the service and nine members of staff, which included the registered manager, regional manager and the deputy manager. We also looked at ten people's care plans, five staff files and a range of records relating to the management of the service such as accidents/incidents, safeguarding, staff recruitment and training, complaints, quality audits and policies and procedures. We requested information to be sent to us and this information was received.

Good

Is the service safe?

Our findings

People told us they felt safe being cared for by staff. One person said, "I always feel safe, yes. I don't know what I'd do if I didn't have my carer maybe I wouldn't then." Another person said, "They [carer] make me feel so safe. I know they lock up properly and they check the house before they go."

There were enough staff deployed within the service to keep people safe. While some staff had mentioned that during busy holiday periods they can be short staffed, they also confirmed the office team resolved this by either helping with calls themselves, or, by asking staff to cover additional calls if they were able. Staff felt there was no pressure on them individually to cover additional calls and the employees we spoke to were happy to help out when required. People felt they had consistency with the care staff providing their calls and hadn't noticed any periods when staff shortages had led to missed or late calls. People told us that if a care worker was going to be late, they would be notified by the co-ordinator. The provider did not use external agencies to provide staffing cover.

The provider followed safe recruitment practices and had robust processes in place to ensure the right staff were employed to care for people safely. This included ensuring that a potential care worker provided a full work history with no unaccounted for absenses, satisfactory referencing, photgraphic identification and a Disclosure and Barring Service check (DBS). The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. These had all been completed satisfactorily.

Staff gave good examples of how to recognise the signs of abuse and how to report their concerns if required. Members of staff told us they would go to the registered manager or deputy manager in the first instance and had every confidence that their concerns would be dealt with swiftly and effectively. Staff were aware of the whistleblowing policy and whom to contact should they feel their concerns were not being dealt with by the provider's management team.

The provider operated a safe medicines management service. Staff were trained in medicines administration processes and completed competency assessments to ensure they were skilled to safely assist people with their medicines. Medicines administration records (MARs) were completed accurately which ensured people received the right medicines at the right time. People's support with their medicines was mainly limited to prompting and reminding them. Staff supported people with prescribed medicines only and where appropriate these were provided in a blister pack system.

The provider safely managed risks to people's health and well-being. Where a risk was identified, for example, where a person might display behaviours which may challenge others, or environmental risks within a persons home, a thorough up-to-date assessment was in place to safely mitigate the risk to the person and to staff with evidence of periodic reviews.

The provider had an infection control policy and provided training to support staff in managing infection control practices within the community. During our inspection we saw that staff were up-to-date with this

element of their mandatory training. Personal protective equipment (PPE) was provided for staff when caring for people. This included gloves and aprons to keep people and staff safe from the spread of infection.

When an incident occurred within the service, the management team would discuss this during staff team meetings. This was to ensure learning was shared with staff and best practice was implemented to attempt to prevent reccurrence. We observed minutes from staff meetings during our inspection that recorded how learning from incidents was shared with staff.

Requires Improvement

Is the service effective?

Our findings

People told us that the members of staff caring for them were skilled and well qualified to care for them. One person said, "They do a lot of training I think". Another person said, "Oh yes, I know they do the training they need."

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.

During inspection we observed care plans and we looked at the issue of consent and capacity. Where a person has been assessed as not having capacity to consent to their care, another person can apply to hold a Lasting Power of Attorney (LPoA) for health and welfare to do this on their behalf. This is usually undertaken by a family member or someone significant to the person. Once a LPoA order is granted, the holder has authority to make decisions about a person's wellbeing, care and support, in their best interests and on their behalf.

Out of the ten care plans we observed during our inspection, there were seven care plans identified with consent to care not having been signed by the person it related to. For example, in one care plan a person's daughter had signed the consent paperwork as it stated the person receiving care had dementia. However, further on in the care plan it stated, 'will any other person sign on behalf of the service user?', the answer in the plan stated 'No'. There was no LPoA present to confirm that the person's daughter had authority to sign documentation on their behalf. Another care plan stated that the person's relative had LPoA but again this was not filed within the care plan or available within the office. There were two care plans where it had been written that people had capacity and the records showed that people had signed their own consent forms. There was one care plan where a person had been assessed as having no capacity, a relative had signed on their behalf and the LPoA for health and welfare had been filed within the person's care plan. We discussed this issue with the registered manager, who took immediate action to remedy the situation. They told us that they would review every care plan to ensure adherence with the MCA. We observed that the registered manager was rectifying this issue during our inspection. A further two care plans had been signed by relatives with no mention of LPoA or documents to suggest orders had been granted.
We recommend that the registered manager continue to review the care plans with a view to capacity and consent in accordance with the Mental Capacity Act 2005.
New staff received a comprehensive induction and the opportunity to shadow experienced colleagues to gain an understanding of what would be required of them within their roles prior to starting work unsupervised. All staff were supported by the provider with annual mandatory online training that ensured staff were up-to-date with the latest practices, information and knowledge to enable them to carry out their roles effectively. Spot checks were completed to ensure that staff were skilled to carry out their work and regular supervision and annual appraisal was completed for all staff. During inspection, we looked at the training matrix and identified that staff were up-to-date with their mandatory training which looked at

elements such as infection control, the Mental Capacity Act and safeguarding adults.

People were supported where required to maintain adequate nutrition and hydration. It was noted in care plans where people required assistance with meals and where people were to have food and drinks left for them within their homes for them to consume later in the day. Care plans reflected what foods people preferred and how they liked to take their drinks, for example tea with lots of milk and sugar. Where people were unable to communicate what they might like to eat, staff were advised of a list of the person's food preferences, and they could suggest a few choices for the person to consider when their care workers called to support them.
When people required support from health or social care professionals, we saw examples of when this had been accommodated by staff. For example, one person was unwell when their carer visited and required a GP. The co-ordinator in the office was alerted and the GP was called. The service had developed good working relationships with the local authority and they told us during our inspection how they would regularly liaise with care managers and other social care professionals to discuss any concerns they had regarding people using the service or people who were going to be supported by the service and how together they may resolve any identified issues to improve outcomes for people. Evidence of these discussions were observed in people's care plans.

Good

Is the service caring?

Our findings

People told us that the service was very caring and we observed during our inspection that the management team had looked at innovative ways of providing compassionate care and support to people using their service. One person said, "They are very caring and very kind, honestly nothing is too much trouble." Another person said, "I see myself very lucky being with Mayfair, they are all good and kind."

The regional manager had developed a new 'Wellbeing Framework'. It had been introduced into the service and other provider services the year prior to our inspection and was showing signs of becoming embedded. The framework had been aimed at tackling loneliness amongst people using their services, continuing to uphold the dignity and respect of people, improving their quality of life and to support the families of the people using the provider's services.

The management team had implemented a number of practical initiatives to produce tangible outcomes from the framework. For example, the service had introduced 'wellbeing checks' where senior care workers and care staff, visited a person to sit and talk to them about how they were, without having to complete any specific care tasks. One person told us, "It was nice to have a chat with [named carer], just to sit and chat for a while." While not everyone we spoke to had experienced a well being check, some people had, and those people were very happy with the outcome. With a longer term view in mind to tackle loneliness staff had been fundraising to be able to provide a Christmas dinner at a local community center for people who used their service and who may not have family or friends to celebrate with over the Christmas period. Staff were excitied when they told us about their fundraising efforts, and about how they had already arranged the venue and food provision for the event. Fundraising events involved staff and people. Included a wheelchair basketball event and a buffet with a raffle where prizes were donated from local businesses.

To further promote the Wellbeing Framework, the provider recognised the need to support family members or significant people who may be the main carer for the person the provider was supporting. This focussed on recognising that caring for someone at home full time can sometimes be stressful and ensuring that families of people using the provider services could be offered support by other organisations. The provider would find out more information on their behalf and signpost them to the organisation or professional who could provide help, guidance and potentially practical support. The management team were looking at a range of services who might be able to provide support to families in caring for people in the future.

To look at promoting people's dignity and respect, other measures had been introduced. These included 'Dignity in Care workshops' which were held for staff and dealt with how to deliver care to people whilst considering their privacy and dignity. One member of staff told us about the workshops, "It is helpful, it just reminds us of how people feel receiving care." A longer term plan was to introduce joint workshops, where people and staff had the opportunity to discuss any frustrations they had about care provision and how they could work together better.

The service ensured that people had access to the information they needed in a way they could understand it and were complying with the Accessible Information Standard (AIS). The Accessible Information Standard

is a framework which was put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We observed during our inspection that care plans contained information about how a person was able to communicate and how they preferred to receive information. In one section of the plan it stated that the paperwork within the care plan was available in other formats, for example large print, other languages or pictorial format; it prompted staff to ask this question of people and to write what a person's preference was, recording what had been requested and when this was to be actioned.

People received care and support which reflected their diverse needs in relation to the seven protected characteristics of the Equality Act 2010. The characteristics of the Act include age, disability, gender, marital status, race, religion and sexual orientation. Peoples' preferences and choices regarding these characteristics were appropriately documented in their care plans. We saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this

Good

Is the service responsive?

Our findings

People said they were satisfied their care plans met their needs and the provider in general was responsive to their wishes. One person said, "I don't know exactly what's in my care plan, I don't need to look. All I know is that everything is done as it should be, the way I like it." Another person said, "They've gotten to know me well. I get a say in what happens and they look after me. What more does anybody need? "

People's care plans were produced following an initial assessment by the team leader and from information that was given to the provider by the person's care manager. The care plans reflected people's individual needs and detailed the care and support to be provided. People's preferences and wishes were considered and people had the opportunity to contribute to their care plans both at the initial stage and during the periodic reviews. If a person's needs changed, for example, if they had been in hospital, care plans were immediately reviewed upon their discharge home to ensure that the level of care within the care plan was sufficient to continue to meet the person's needs.

Care plans were individualised and included, for example, what interests a person might have and how a person liked to spend their time. They included social histories that provided a holistic view of the person and what their lives had been like prior to receiving services. It was evident when talking to staff and in observing the office environment that staff knew people well.The care plans recorded the objectives of the care provision and the individual person's desired outcomes.

Records were kept by care workers of the daily care and support given to people. These were in the form of care books that were kept in people's homes. This information provided details of the care provided to people during calls and general observations of how the person was feeling that day. This information would be read by the staff member who next visited which helped to give them an up-to-date understanding of the person's wellbeing that day.

The service was not supporting any one at the end of their life during our inspection. However, we discussed with the registered manager what provision was in place to accommodate a person at the end of their life. The registered manager told us that the care plan would be very individualised, it would be completed as part of a mutli discipliniary team and care would be centred around the person's needs and wishes. The registered manager mentioned the importance of also being available to suppor the person's loved ones during such a difficult time. The provider had an end of life policy in place which the registered manager referred to during our discussion.

The provider had a complaints process in place. During inspection we saw examples of how complaints were recorded, investigated and closed within policy timescales and to the complainant's satisfaction. People had information in their homes about how they could make a complaint about the service if they wished. We observed the provider to be open and honest about complaints, the ensuing investigation and what the overall outcomes had been

Good

Is the service well-led?

Our findings

People and staff gave very positive feedback about the registered manager and the overall management of the service. One person said, "They [registered and deputy manager] are fantastic, any problems, they'll sort it." One staff member said, "What I like is that you can go to them [registered and regional managers], talk to them and they listen, they help you." Staff told us and we observed during our inspection that the registered manager and regional manager promoted a culture of transparency and openness. They were highly thought of by staff and by people using the service.

The new Wellbeing Framework had been introduced to ensure that people and staff felt supported and valued. As part of this framework the provider had developed practical initiatives to encourage staff to join the workforce and to ensure that once recruited, staff wanted to remain within the provider's employ. A new post had been created for a Recruitment and Wellbeing Officer, the main purpose of this role was to look at recruitment and retention and to ensure that staff felt valued within the Wellbeing Framework. We spoke with the Recruitment and Wellbeing Officer during our inspection. They told us that since the Wellbeing Framework was introduced a year ago, the staff retention rate had increased. They also told us that the provider was looking at more innovative ways to recruit new care workers as the competition was high. The Recruitment and Wellbeing Officer had linked in with local Job Centres to meet new potential candidates, given presentations in colleges and attended job fayres. They told us that they were also looking for staff who had caring values and were being selective about whom they recruited, this view was imposed upon Job Centres when potential new candidates were selected. The Wellbeing and Recruitment Officer told us, "We are looking for people who are really going to care for our service users."

The service had signed up to the 'Disability Confident Scheme' with the local Job Centres. This scheme required a commitment from the provider to actively promote non discriminatory processes when considering potential employees who may have a disability. For example, to provide support through the application process, including extra time to complete applications and tests, to hold interviews in more informal settings and to use a range of mediums when contacting candidates, such as SMS, email and letter. This had been successful in the most recent recruitment for new care staff and a care worker had been employed as a result of implementing the scheme.

Similarly, the provider had committed to the Armed Forces covenant in which the service agrees to actively provide non discriminatory processes with regards to an acting or retired member of the Armed Forces or their families and to consider what practical measures may be required to support them through the provider recruitment process and beyond. For example, this included granting emergency leave for a partner of an acting Armed Forces employee when they were to be deployed at short notice.

The provider had subscribed to 'The Care Workers Charity' as their charity of the year. The charity provided financial grants to careworkers experiencing various personal difficulties and the provider's care workers could be referred for these grants as part of the Wellbeing Framework. Staff were able to open a 'Wellbeing Case' in which they in confidence, wrote to, or telephoned the Recruitment and Wellbeing Officer to discuss any issues that may be concerning them, either within the workplace or at home. The Recruitment and

Wellbeing Officer would then meet with the member of staff discreetly, to discuss the concerns and to put a plan in place to resolve issues where possible. For example, one person was offered reduced hours to assist them with their difficulties. Staff told us that they knew how to open a Wellbeing Case if they wished and for staff who had already done so, their situation had improved as a result.

In order to promote equality and diversity within the workplace and to reflect the provider's diverse workforce, the registered and regional manager, alongside input from the Recruitment and Wellbeing Officer, had introduced 'Diversity Thursday'. Each week, care workers would be invited to join the office staff for lunch in the locality office, the lunch was representative of a different country each week, often a country that one of the provider's staff was from. For example, there had been a lunch during which Polish food had been provided. The registered manager told us that it encouraged discussion about people's differences and had led to a more cohesive workforce. It also encouraged team working, as the management team recognised that it can sometimes be isolating for staff working within a community setting. Staff told us that this had been 'fun' and they 'looked forward to it'.

Members of staff told us about an occasion when they felt that the management team had gone the extra mile for them. On one occasion, during the adverse winter weather conditions earlier in the year, the office staff had stayed later in the office, well in to the evening until the care workers within the community had finished their calls. This was to provide practical support with travel arrangements if required, providing an extra care worker if necessary and during this period office staff organised hot drinks for care workers to access at the office in between their calls.

The service recognised the achievements of staff. Members of staff told us they had been encouraged to develop by completeing additional non-mandatory training, relevant to the role they wanted to progress to. Of the staff we spoke to during inspection, a number of these had been promoted internally and continued to be supported by the management team to develop further. There was an annual awards ceremony in which people using services voted for members of staff to recognise their individual achievements and contributions and there was a 'Care Worker of the Month' certificate awarded each month.

The registered manager had introduced a 'Shout out board' in which all staff and people using the service could comment about things that people had done well. These comments were then stuck to the board for all staff to see. A selection of these comments included, 'thank you's' from social care professionals for the care provided to people, thanks to a care worker for picking up a last minute call and a well done to staff for covering over a busy holiday period.

The provider had management systems and audit processes in place to monitor the safety and effectiveness of service provision. This enabled the management team to look at any areas identified for improvement and act upon them as necessary. This information fed into a weekly report that was then analysed by the provider's head office, with feedback being sent directly to the locality office. However, the quality processes in place had failed to identify the lack of LPoA documentation within people's care plans.

Feedback was sought from people using an annual satisfaction survey. This was sent out corporately with information received analysed and disemminated to each locality office. The feedback received at the Portsmouth branch was largely positive and where any areas of improvement had been identified these had been addressed by the registered and regional managers.