Sevacare (UK) Limited

Mayfair Homecare - Hounslow

Inspection report

Ashley House
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Date of inspection visit:
15 October 2018

Date of publication:
10 December 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection took place on 15 October 2018 and was announced. We gave the service manager two working days' notice as the location provided a service to people in their own homes and we needed to confirm a manager would be available when we inspected. The last comprehensive inspection of the service was on 5 May 2016 when we rated it good.

Mayfair Homecare is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults, some living with the experience of dementia, people with learning disabilities and people with mental health needs. Most people funded their care through direct payments. At the time of our inspection 43 people were using the service. Mayfair Homecare Hounslow is a branch of Sevacare, a private organisation which has multiple domiciliary care agency locations around England.

The provider had been planning to close the Hounslow location in July 2018 as one of their contracts had ended. Due to a significant number of people using the service requesting to remain with Mayfair, in September 2018, they made the decision to continue providing a service and to remain open.

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 in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection, the registered manager was on maternity leave and a colleague from within their team was covering the post in their absence.

During the inspection we found risk management plans did not always have clear guidance for staff to follow to minimise possible risks to people using the service. Audits did not effectively identify this.

The support plans did not record any information around people's wishes, views and thoughts about end of life care but the service manager said this would be addressed.

Care workers had relevant training, were able to identify the types of abuse and knew how to respond to any safeguarding concerns.

There were enough care workers employed to meet the needs of the people using the service. They had the relevant training, supervision and appraisals to develop the necessary skills to support people. There were safe recruitment systems in place to ensure care workers were suitable to work with people using the service.

The provider had systems to ensure people received the medicines they needed safely and as prescribed.

Care workers had access to personal protective equipment and infection control training.

The provider assessed people's care needs and recorded their preferences about how they received care and support.

When it was part of their support plan, care workers supported people to maintain a balanced diet.

People's support plans included information about their health needs, and where required, people were supported to access appropriate healthcare services to maintain their health and wellbeing.

The principles of the Mental Capacity Act (2005) were followed. Care and support was provided with people's consent or in their agreed best interests.

People using the service were happy with the care they received and were involved in making decisions about their care. People told us they had the same care workers and this provided consistency of care.

People told us care workers treated them with kindness and respect.

People using the service said they received personalised care that was responsive to their needs. Reviews were completed annually or as and when required.

The provider had a procedure for responding to any complaints they received. People had information on how to make a complaint and knew how to if they needed to.

The service had systems in place to monitor, manage and improve service delivery. This included a complaints system, audits and care worker observations

People using the service and care workers told us the managers were accessible and responded to any concerns raised.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to risk management. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk management plans were not always robust enough to help minimise the risk of harm to people.

Safeguarding and whistle blowing policies were up to date and staff knew how to respond to safeguarding concerns.

There were a sufficient number of care workers employed to care for people and safe recruitment procedures were followed to make sure they were suitable to work with people using the service.

The provider had systems in place for the safe management of medicines.

The provider had an infection control policy in place and the care workers had access to personal protective equipment and infection control training.

Is the service effective?

Good

The service was effective.

People's care needs were assessed and their preferences recorded about how they wished to receive their care.

Care workers were supported to develop professionally through training, observations, supervision and annual appraisals.

Where it was a part of their support plan, people were supported with their dietary requirements. Staff also supported people to meet their healthcare needs.

The principles of the Mental Capacity Act (2005) were followed.

Is the service caring?

Good

The service was caring.

People using the service spoke positively about the care they

received and said care workers treated them kindly and with respect.

People were consulted about their care and the support they received.

Is the service responsive?

Good

The service was responsive.

People were involved in planning their care. Support plans included people's preferences and guidance on how they would like their care delivered to meet their identified needs. Reviews were held at least annually.

The support plans did not record information around people's wishes, views and thoughts about end of life care, but this was being addressed.

The service had a complaints procedure and people knew how to make a complaint if they wished to.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had several data management and audit systems in place to monitor the quality of the care provided and make improvements, but the systems were not always effective as they did not identify that risk management plans were not always robust enough to help minimise risks to people.

The provider had an open culture that promoted feedback from all stakeholders.

People using the service and care workers felt managers were accessible and said they listened to any concerns.

Mayfair Homecare - Hounslow

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 15 October 2018 and was announced. We gave the manager two working days' notice as the location provided a service to people in their own homes and we needed to confirm the registered manager would be available when we inspected.

The inspection was conducted by one inspector.

Prior to the inspection we looked at the information we held on the service including notifications of significant events and safeguarding. 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. We also contacted the local authority's safeguarding team and commissioning team and received their feedback about the service.

During the inspection we spoke with the manager covering the registered manager's post, the service manager and seven care workers. We viewed the care records of 11 people using the service, the employment files for 10 care workers which included recruitment records, supervision and appraisals and we looked at training records for all staff members. We also viewed the service's checks and audits to monitor the quality of the service provided to people. After the inspection visit we spoke with nine people using the service and one relative.

Requires Improvement

Is the service safe?

Our findings

During the inspection we saw that the provider carried out a number of assessments to identify possible risks to each person using the service and to the care workers in the person's home environment. However, where they identified risks, there was not always clear guidance on how to reduce the possibility of risk. For example, the provider had risk assessments that included skin integrity monitoring and developing pressure sores. For two people who used the service, we saw their skin integrity risk assessments indicated a high risk but there were not specific risk management plans to minimise the risks identified in the assessments.

In one person's risk assessment we saw the person was 'prone to having falls' but we did not see a falls risk assessment. When we queried this, the assessor told us it was not that the person was prone to falls but that they did not want care workers to rush the person. This meant the information presented was incorrect and therefore the guidance not relevant. The assessor said they would change the wording to reflect the person's needs. We spoke with the managers about a second person's falls risk assessment not being detailed enough. The manager updated that risk plan and several others and emailed them to us the day following the inspection. However, although the risk assessment had been updated there was not a robust risk management plan to provide clear guidance on how to minimise the risk of harm and to support people safely.

In one person's file, the medicines risk description record was not a description of the risk but guidelines for how to support the person. Descriptions lacked detail. For example, they recorded the person required cream to be applied but was not specific about what cream or where to apply it.

Risk management plans appeared to be an ongoing issue as the last branch audit completed in June 2017 recommended that, 'More detailed information required in Risk Management Plans.'

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

Some risk assessments and risk management plans were completed appropriately. Personal moving and handling risk assessments we saw recorded the number of care workers required to move the person, how to reduce risk and included a manual handling equipment service record. One person who was at risk of a stroke had a risk assessment that provided information of the signs of a stroke that care workers needed to look for and provided guidelines for what action to take if they observed the signs. Each person also had an environmental risk assessment completed for their home to reduce the possible risks to both them and the care workers.

People using the service and their relatives told us they felt safe. The provider had whistle blowing and safeguarding policies and procedures in place that provided guidance for care workers to help protect people from abuse. Care workers told us they had completed safeguarding training and the training records we saw confirmed this. The care workers we spoke with were able to identify different types of abuse and knew what action to take if a safeguarding concern arose. Care workers said, "I would speak to my line

manager", "I call my line manager and let them know" and "I must report to the line manager or the Care Quality Commission."

The manager was aware of their responsibility to raise, record and report safeguarding adult alerts to the relevant agencies including the local authority and the Care Quality Commission (CQC). We saw evidence that where a safeguarding concern had been raised, the provider took appropriate action to notify the police, social services and the CQC and completed an internal investigation to protect people who were at risk of abuse.

When an incident or accident had been reported, it was investigated and a record was made of what could have been done differently and what follow up action was taken. However as this was completed by the care worker, we discussed with the managers the need to record their learning for overall service improvement and delivery in addition to the learning recorded on the incident form.

During the inspection we viewed the recruitment files of ten care workers. There were systems in place to ensure suitable care workers were employed to work with people using the service. The files contained checks and records including application forms, interview questions, two references, identification documents and criminal record checks. This meant the provider employed care workers who were suitable to provide safe and appropriate care to people.

There were enough staff to meet people's needs. People we spoke with said they had regular care workers who generally arrived on time and if there was a change of care worker the office let them know in advance. Comments included, "If a cover care worker can't come. They phone and let us know. It doesn't happen very often", "[Relative] seems to get regular carers and they don't change them around. When they do change carers they all seem to know [relative]", "I'm not sure they always arrive on time, but they stay for the correct amount of time", "Staff come on time and stay longer if needed" and "They do come on time." Care workers told us they had enough time between calls, although traffic could sometimes delay them. One care worker noted, "[Managers] are very good. They give all my calls in one area." Until the week before the inspection, the service was using a call monitoring system to ensure care workers were completing their visits as required. In the absence of this system, the managers told us they would be increasing spot checks and phone monitoring. The service manager said they tried to match people and care workers by locality and preferences based on need, for example matching with care workers who spoke the same language.

People received their medicines as prescribed and in a safe way. Care workers undertook annual medicines training and all care workers had regular spot checks which included observations of medicines administration.

Medicines administration records (MARs) contained clear information about people's medicines. There were also medicines risk assessments and information about people's medicines needs within their support plans. The medicines risk assessments provided details about the medicines, who else administered them, for example family members, special instructions and if special training was required, for example for warfarin. People using the service had signed a medicines agreement form to indicate they understood care workers could not administer non-prescribed medicines and if the person refused their medicines, this would be reported to the person's GP. MARs were audited monthly to check they were being completed correctly and minimise the risk of medicines errors.

People were protected by the prevention and control of infection. The provider had a risk assessment for infection control and had provided training to care workers. Care workers we spoke with said, "I use personal protective equipment all the time. I come into the office for gloves, aprons, shoe covers and hand

gels. I always wash my hands" and "I use my gloves and change for each task." Spot checks ensured care workers were using personal protective equipment, such as gloves and aprons.

Good

Is the service effective?

Our findings

Prior to people starting to use the service the provider assessed people's needs and choices to ensure they could provide the required support. New referrals were mostly from the local authority and the local authority assessment of the person was used along with the provider's assessment to form the basis of the support plan. When they were able to, the support plan was signed by the person using the service to indicate they agreed with it and reviewed six monthly or more frequently if required. The support plan had a section that indicated their preferences and how they would like to be cared for.

People were supported by care workers who had the skills, knowledge and experience to deliver effective care and support. People told us, "I find them [care workers] very helpful, if there is a problem, they sort it" and "[Care workers] are very good and very nice. They send someone whenever I need them. They know what they are doing." A commissioner wrote to us, "…we found them to be a good reliable provider with well trained staff..."

New care workers were enrolled on training and shadowed more experienced care workers as part of their induction. Care workers we spoke with indicated they had regular refresher training and this was confirmed by the training data base.

The provider undertook unannounced observations of care workers in people's homes and made telephone monitoring calls to people to get feedback on the service provided. Care workers also attended team meetings and supervision sessions where good practice was discussed. Care workers found supervision helpful and comments included, "Supervision is every three months. They listen to me about any concerns. They help me a lot" and "[Supervision] tells you about good and bad and comments from clients. It makes me more aware."

People's support plans had information about their dietary needs and what support, if any, was required. Care workers told us, "Most food is ready meals. I will ask them what they like to eat and the person will tell me exactly what they want" and "I would know the diet restrictions from the care plan."

People's health needs were recorded in their support plan and they were supported to have access to healthcare. Health needs were discussed during the initial assessment and reviewed regularly. The provider had liaised with other healthcare professionals such as GPs and district nurses to arrange the support people needed to stay healthy.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

Care workers told us they had received training around the MCA and the training data base confirmed this. People we spoke with said care workers asked them about choices and they made their own decisions. Comments included, "I have a good carer. She does it exactly as I want" and "They ask me what I want."

The provider had several forms for people to consent to various activities such as consenting to their care or sharing information. Where appropriate people had signed forms to give their consent to aspects of their care. Where a person lacked the mental capacity to make decisions, we saw the provider had completed a decision specific mental capacity assessment as part of making decisions in people's best interests.

Good

Is the service caring?

Our findings

People using the service and their relatives told us the care workers who supported them were kind and caring. Comments included, "I am so satisfied with the carer I have", "They are good carers. They look after me alright", "They are always kind. I have had them for a while", "The carers are very polite. They don't come in and rush you. They are very understanding" and "[The carers] are very good. I can't find fault."

Care workers we spoke with said they treated people with dignity and were respectful of their choices. They were all positive about the care and support they provided and were aware of people's individual needs and preferences. Comments from care workers included, "I always read the care plan before I go into a new service user", "I read the support plan and then ask them, how I can help them. When I do personal care, I ask if it is okay", "If people can do personal care by themselves, I let them. I ask if everything is okay and if they are happy", "[People using the service] could have Alzheimer's or dementia but we try and promote independence. If they can do something I don't take it away, like dressing themselves." When we asked about care workers knowing about preferences one person said, "The carers are really good, they know how to shower me and what shower gel I like." Another said, "[During personal care] they are very respectful. I have no problem with them."

People's support plans indicated their cultural and religious needs. Care workers respected people's preferences and told us, "When I go there, I respect their culture. A [religious person] likes to cover their hair, so I do that after washing it" and "Some people wear a scarf. Some people need to pray at certain times, so I wait for them to finish first."

People using the service and their relatives were involved in planning their care and told us they had support plans that were reviewed with them. We saw that support plans included information about people's preferences and how they wished to be cared for.

Support plans included guidelines for how people like to be addressed, if they required an interpreter and what gender of care staff they preferred. In the communication section it was recorded if people required visual aids or used sign language to communicate.

People using the service and care workers were from diverse backgrounds and the manager told us they tried to be mindful of matching people's needs such as culture and language with a care worker of a similar background. This meant people were being cared for by care workers who had a good understanding of their background and who could communicate with them in their first language.

Good

Is the service responsive?

Our findings

People using the service told us that they received personalised care that was responsive to their needs. People said, "[Relative] has a care plan in the book and the agency came to see us to update it" and "We do have a care plan that was drawn up in the beginning." The support plans we viewed were based on the initial assessments of people's needs and included their preferences and choices that were relevant to their care.

The support plans contained a brief history of the person, first language, next of kin and other people involved in the person's care. They included information about people's cultural and faith needs and the provider had an equality and diversity policy. The support plans we reviewed also indicated people's preferences and routines, which provided guidance for the care workers on how to provide support and they were signed by the person using the service. They were outcome based and reviewed six monthly to reflect any changes in care required. Care workers completed daily logs. These were mainly task orientated but indicated people were receiving care that reflected their support plans. Managers audited them monthly.

At the time of the inspection no one was receiving end of life care from the provider and the support plans did not contain any information around people's wishes, views and thoughts about end of life care as this had not been considered as part of the care planning process. We discussed this with the service manager who said they were aware of this and planned to incorporate information on end of life care into their updated support plans.

The provider had a complaints procedure and policy and people we spoke with knew how to make a complaint. People's service user agreements contained the complaints procedure and relevant contact details. These were available in different formats. Comments included, "Absolutely I know who to complain to. I would just go to the office. I am always popping in and out and they are all very nice", "I'm not complaining. I would speak to the manager is I needed to" and "If I have concerns I speak to [staff member] or the manager." The person gave an example of a care worker that was not suited to their needs and said "[Staff member] came around to the house and asked what was wrong and she sorted it out there and then." We saw that complaints, including safeguarding alerts, were investigated and recorded with supporting documents, in line with the provider's complaints procedure and appropriate action was taken. However, the outcomes and learning were not clear and we discussed clearly identifying these as part of the manager's role for overall service improvement.

Requires Improvement

Is the service well-led?

Our findings

During the inspection we found that the provider was not consistent in their risk assessments and risk management plans were not always robust. The audit of people's files had not identified this, which meant people were at risk of not having their needs met in a safe way.

We also saw that when safeguarding alerts, complaints and incidents were addressed there was no clear indication of what the provider had learnt or how they had used the information to identify areas to improve service delivery.

We discuss these concerns with the management team and they told us they would make the necessary improvements.

The provider had quality assurance systems in place to monitor service delivery. Quality assurance checks included phone monitoring and home visits. A percentage of daily logs and everybody's MAR charts were audited monthly. Until this year, when the service planned to close, an annual audit was also carried out by a manager from Sevacare head office which included recommendations and an action plan. The service manager told us, as the service was now remaining open, an audit would be carried out before the end of the year.

There was a system in place to monitor and improve the quality of the service provided and the manager audited people's care files. We saw evidence that the care files for people using the service were checked for ongoing information such as complaints procedure discussed, medicines assessments and risk assessments completed.

The plans to close the location meant that areas that required improvement such as end of life care had not been addressed and the auditor from the head office had not been in the last year. However, the service manager told us these areas were being addressed now that the service was remaining open.

At the time of the inspection the registered manager was on maternity leave and arrangements had been made for a colleague from within the team to cover the registered manager's post in their absence. The service manager who had previously been a registered manager at the location was also involved in providing support to the location.

The manager had an overview of when supervisions and training were due to ensure care workers were provided with the support and training they needed to provide effective care.

People using the service and their relatives told us they felt the service was well managed and they could contact the office if they had any concerns. One person also noted that, "Occasionally they come [to my home] from the office to ask how things are."

People using the service had the opportunity to give feedback to the provider. The provider carried out

regular phone monitoring calls and undertook spot checks of the care workers' practice in people's homes. In addition to supervisions and appraisals, care workers also had the opportunity to participate in team meetings and share information. One care worker said, "In the team meeting [managers] tell us what is going on, the future and any concerns."

Care workers we spoke with were enthusiastic and committed to providing a good level of care. They told us they felt supported by their managers and could speak with them about any concerns. Comments included, "I feel supported. They give me advice all the time", "From the manager to the care co-ordinator, they are good. They listen to me and respect my concerns", "They're very good. My co-ordinator respects me. She will tell me, you have done a great job and that encourages me" and "The manager is good. If I don't understand something, I call her and she gives me advice."

We saw the provider had up to date policies and procedures. Care workers were aware of the visions and values of the service and told us they were kept informed of changes. In addition to training, the provider also sent out monthly memos to care workers with service and practice updates to support care workers' good practice.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not always done all that was reasonably practicable to mitigate the risks to the health and safety of service users. Regulation 12 (1)(2) (b)