Maycare Limited

Maycare

Inspection report

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23 June 2021
24 June 2021

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Maycare is a domiciliary care service personal and support to people in their own homes. The service was supporting 61 people at the time of the inspection. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
The provider did not have an effective system in place to ensure staff were safe to work with people who received care.

People's care was not provided for the amount of time commissioned in order to meet their needs. Records consistently showed visits were shorter than the scheduled call and people confirmed visits were shorter than planned.

People told us staff were rushed, they had several visits booked in at the same time and did not arrive at a consistent time. This impacted on their well-being, for example, by staff being very early or very late to provide their support. People were not always contacted to say their carer was going to be late.

Some people needed support with their meals. When staff arrived late, this meant they were waiting for a meal.

Staff told us they had up to four calls scheduled for the same time and that they needed to 'jiggle' people around to fit them in. There was no travel time built in between care calls. This meant calls were not scheduled according to people's needs or preferences and people waited to use the toilet and receive support with personal care.

We heard two conversations in the office, where staff and management had not respected people's wishes, regarding the staff who visited them, or the timing of a visit.

The provider had not identified the concerns we found during the inspection.

The provider did not have an effective system in place to monitor when staff arrived at a person's home, or when they left. The system did identify the length of the visit, which was usually shorter than commissioned. The provider had not understood this concern nor did they understand the impact upon people when calls were late or shorter than they should have been. The provider was not always promoting a person-centred and empowering service and people did not always receive good outcomes.

People's needs were assessed before support was offered. Where people needed the support of two staff, staff arrived at the same time. Records showed people usually received visits from the same staff team

which meant staff knew people well.

The provider had a safeguarding policy and procedure in place. Senior staff were aware how to refer concerns to the local authority safeguarding teams and gave an example of when they had done so.

People were supported by staff who had received on-line training in medication awareness.

We were assured that the provider was using personal protective equipment (PPE) effectively and safely and staff had twice weekly tests for COVID-19.

Staff based in the office were clear as to what their individual role was and what areas of work they were responsible for.

The provider contacted people up to twice a year to undertake a formal review of their care. If people's needs changed, or if they expressed concerns, reviews could be held more frequently than twice a year.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 26 September 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection not enough improvement had been made and the provider was still in breach of regulations.

The service remains rated requires improvement.

Why we inspected
We carried out a focussed inspection of this service on 23 and 24 June 2021. We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Maycare on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe recruitment, care which meets people's commissioned needs and preferences and governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.
Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.
Details are in our well-led findings below.

Maycare

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was undertaken by one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

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
This inspection was unannounced.

Inspection activity started on 23 June 2021 and ended on 13 July 2021. We visited the office location on 23 and 24 June 2021.

What we did before the inspection
We reviewed all information we had received about the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
During the visit to the office, we reviewed a range of paper and computer records. These included care plans and associated records for five people, three staff recruitment files and policies and procedures. We spoke with the registered manager who is also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with two staff who were based in the office. After our visit to the office, we spoke with three people who used the service and four relatives of four different people. We spoke with four staff who supported people with their personal care.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at further records which were sent to us electronically.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- The provider did not have an effective system in place to ensure staff were safe to work with people who received care.
- New staff did not have a Disclosure and Barring Service (DBS) check in place before they started working with people. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. This meant people could be at risk from being supported by unsuitable staff.

The failure to ensure staff were safe to work with people was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People did not have their care provided for the commissioned amount of time they had been assessed as needing.
- Records consistently showed visits were shorter than the scheduled call. For example, half hour calls varied in length between three and 26 minutes.
- People confirmed visits were shorter than planned. Whilst some told us they were happy for staff to leave the call earlier, they were still charged for the full time.
- People told us staff were rushed, had several visits booked in at the same time and did not arrive at a consistent time. This impacted on their well-being, for example, by staff being very early or very late to provide support at mealtimes. People were not always contacted to say their carer was going to be late.
- People's support needs included personal care and support using the toilet. Staff told us they had up to four calls scheduled at the same time and they needed to 'jiggle' people around to fit them in. One staff member told us, "We have to work around it, we see where they are, if one's nearer to another." There was no travel time between care calls built into the system. This meant calls were not scheduled according to people's needs or preferences and people waited to use the toilet and receive support with personal care.
- Some people needed support with medicines which needed a specific amount of time between doses. The registered manager told us where a visit had been delivered later than scheduled, the next visit would also be delayed to ensure the spacing was correct.
- Some people needed support with their meals. When staff arrived late, this meant they were waiting for their meal.
- During the inspection, we heard two conversations in the office, where staff and management had not respected people's wishes, regarding the staff who visited them, or the timing of a visit.

The failure to provide appropriate care to meet people's needs and reflect their preferences was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people required the support of two staff, for example, for the use of a hoist. Staff were therefore allocated to work with another staff member and stayed together throughout their shift. This meant staff arrived at the same time to support a person.
● Records showed people usually received visits from the same staff team which meant staff knew people well.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This meant one person was put at risk because a full assessment of their needs was not in place before support was provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17 regarding this concern.

● People's needs were assessed before support was offered.
● The provider had a safeguarding policy and procedure in place. Senior staff were aware of how to refer concerns to the local authority safeguarding teams and gave an example of when they had done so.
● Staff had received training in safeguarding and were aware of the different types of abuse. They said they would report any concerns to the registered manager.

Learning lessons when things go wrong

At our last inspection to provider had failed to ensure there was a formal system to analyse incidents and to take action to improve the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17 regarding this concern.

● During this inspection we asked for information regarding accidents and incidents. Staff looked at records and advised there had not been any since March 2020.
● We saw an example of learning when things went wrong. A safeguarding concern had been raised and upon investigation, it was found staff had not used the electronic recording system correctly. This had meant office staff were not alerted to the concern. Staff had been reminded of how to use the system and to read people's care plans and risk assessment at every visit.

Using medicines safely
● People were supported by staff who had received on-line training in medication awareness. After completing the training they shadowed colleagues supporting people with medicines.
● About a week after staff had completed the on-line medicines training, a senior staff member undertook a 'spot check'. This meant they observed the new staff member supporting people with medicines to ensure

they did so correctly.
● The provider did not have a system in place to formally assess staff competence each year, as directed by national guidance. However, all staff had completed on-line medicines training this year, followed by a spot check to ensure they were safe to support people with medicines. The provider told us they would look into undertaking annual competency assessments.
● People had their medicines supplied in blister packs from their pharmacy and staff completed electronic records to show people had taken their medicines.

Assessing risk, safety monitoring and management
● The provider ensured they undertook an assessment of people's needs and identified risks before they offered people a service.
● Senior staff visited people to assess their needs and included relatives and professionals in the assessment, where appropriate.
● Where people had equipment in their homes, for example, hoists, these were serviced by the relevant professional on a scheduled routine. The registered manager told us they ensured staff checked the equipment before using it. The registered manager also said they contacted the relevant team when necessary to ensure equipment was safe to use.

Preventing and controlling infection
● We were assured that the provider was using personal protective equipment (PPE) effectively and safely. Staff told us they wore masks, aprons and gloves when supporting people.
● The provider and staff told us they had enough PPE supplies.
● We were assured that the provider was accessing regular COVID-19 testing for staff. Staff were tested twice a week in line with current guidance.
● We were assured that the provider's infection prevention and control policy was up to date.

Requires Improvement

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection, we found the registered manager did not have effective quality assurance systems in place. Whilst audits and quality checks were conducted, they did not identify our concerns. There was not a clear leadership structure within the office and staff roles were not clearly defined. Whilst records were accurate and up to date, many records were unavailable or hard to find. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The provider had not identified the concerns we found during the inspection.
- The provider did not have an effective system in place to monitor when staff were present at a person's home, or when they left.
- The system did identify the length of the visit, which was usually shorter than the time commissioned. The provider had not seen this as a concern.
- The provider had not identified or understood the impact upon people when calls were late or shorter than they should be.
- Whilst there was an electronic recording system in place, staff regularly did not log out of calls. The system showed staff logging out of the call up to 3.4 kilometres away from the person's home. The provider had not taken sufficient action to ensure staff logged in and out appropriately.
- Some calls were measured as "0 minutes" or "location not captured" was noted. The registered manager told us this was because staff did not have GPS switched on, on their mobile phones. The registered manager contacted a staff member to discuss this straight away after we made them aware.

The failure to operate effective quality systems was a continuing breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff based in the office were clear as to what their individual role was and what areas of work they were responsible for. Since the last inspection, the provider has made changes to the office team. A new role had been created to monitor compliance regarding records and quality assurance.
- Where records were available, they were located straight away. A staff member in the office had

responsibility to ensure paperwork was filed in an ordered way.
● The provider had submitted statutory notifications about significant incidents that happened at the service as required.
● Staff said they felt supported by office staff and management. One staff member told us, "If I have any queries, I can phone, they help me through it."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People's experience of the care provided was mixed.
● Positive comments included, "It's quite good, [staff] have always turned up and done their job", "[Staff] are very nice", "[Staff] are jolly with [my relative] and understand [them]" and "[Staff] joke and laugh [with my relative]".
● However, people confirmed visits did not last the amount of time planned. Some people said staff did not always come at the time they were expected and they were not contacted if staff were running late. Some people said it had been difficult to contact the office and when they did, their concerns or issues were not addressed.
● One person told us where staff did contact them to say they were running late, they said they could need to see two or three other people before they could get to them. This made the visit much later than planned and had a negative impact on them.
● Our inspection found the provider was not always promoting a person-centred and empowering service and people did not always receive good outcomes.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider understood their responsibilities about duty of candour and told us they apologised if something went wrong.
● We saw written evidence of apologies in response to complaints.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider undertook an annual survey which sought the views of people using the service. However, the most recent survey had been sent out in June 2020 and therefore a survey was due the same month as the inspection.
● The provider contacted people up to twice a year to undertake a formal review of their care. If people's needs changed, or if they expressed concerns, reviews could be held more frequently than twice a year.
● People and their relatives confirmed reviews were undertaken.

Continuous learning and improving care
● There was a system of auditing in place, which included regular checks of records and spot checks of staff when supporting people.
● Staff based in the office and the registered manager were sent alerts by the computer system. For example, if someone had not taken their medicines. However, the system over-alerted, in that it was set up to alert for every missed medicine, for example, where people did not need pain relief. This meant records showed more alerts than necessary and staff had to work around the system.
● Where alerts were correct, these were noted by staff or the registered manager and action taken as required, for example, contacting a healthcare professional.

Working in partnership with others

● The registered manager told us staff were in regular contact with other healthcare professionals such as occupational therapists, physiotherapists and community nurses.

● A staff member told us they contacted office staff because a person's needs were changing. The staff member asked them to contact two healthcare professionals, which they did.

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 9 HSCA RA Regulations 2014 Person-centred care The provider was not providing appropriate care to meet people's needs and reflect their preferences.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system of governance to improve the quality of the service provided.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not have an effective recruitment procedure in place to ensure staff were safe to work with people.

The enforcement action we took:

Warning notice