Domriss Care Limited

Mayfair Homecare - Biggleswade

Inspection report

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Date of inspection visit:
21 June 2018

Date of publication:
16 August 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Mayfair Biggleswade is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to adults.

Not everyone using Mayfair Biggleswade receives a regulated activity; the Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

At the time of this inspection Mayfair Biggleswade were supporting 39 people.

We carried out a comprehensive inspection of this service on 21 June 2018. This was Mayfair Biggleswade's first inspection following a change to their registration. The overall rating for this service is 'Requires Improvement'. This is the first time the service has been rated Requires Improvement.

The service had not been monitoring if people had received their care visits. Some people had had missed care visits. This meant that the leadership of the service did not know if people were safe and had received their care visits. Records did not accurately evidence if people had consistently had care visits. As a result of these issues the local authority became involved in the service. Their role was to support the service to make improvements and to check improvements were in fact taking place.

We found that people's risk assessments were not always complete. The accompanying care plans did not fully outline the support people needed. These plans did not give step by step guidance for staff to follow to ensure that people's needs were met and people were safe. In some instances, particular risks which people faced were not explored or identified in these plans.

The management of the service did not have a clear knowledge of the most vulnerable people the service supported.

Staff recruitment checks were not complete. For example, staff did not have full employment histories with any gaps explained. These checks are important as a way of checking people are safe in the company of staff.

When something went wrong lessons were not always taken from these situations. The leadership did not consider what went wrong, and what they could do to try and prevent a similar situation happening again. Robust contingency plans were not put in place and there was no system to check these plans were being actioned and if they were effective.

The management and the provider of the service were not completing robust and meaningful audits to test the quality of the service provided. The concerns identified by the local authority had not been identified and addressed by the provider. Some issues had been identified by the provider such as the quality of

people's care records, but no plan was in place with action taken to address this issue.

The culture of the service and how to test this had not been considered by the provider. Systems were not in place to ensure poor practices did not happen again. The provider had not considered how they had contributed to issues which the local authority had identified. What they could do to prevent these from re-occurring.

The management of the service were also not sharing certain events, which they must do by law, with us at the Care Quality Commission (CQC).

These issues constituted breaches in the legal requirements. There were four breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

People spoke positively about the support they received in relation to their medicines. However, the systems the service used to check that people always had their medicines, were not always effective. For example, when errors were identified robust action was not taken to prevent these errors from happening again.

Staff knew how to identify if abuse or harm had occurred. However, staff did not know what they could do if they believed action was not being taken to respond to their concerns. One member of staff did not see this as their role.

We found that staff were not always given the opportunity to fully get to know people's needs before care visits started. Staff were not given the time and opportunity to look at people's risk assessments and care plans. The service was not testing if staff were aware about the needs of the people they supported.

Staff competency checks were taking place but these were not well evidenced. The management of the service could not have assurances that these assessments were thorough and that staff had the skills to do their job well.

Staff knowledge was not being routinely checked. Staff training was up to date but staff did not receive training in all the areas which effected all the people they supported. The management of the service had not considered this issue before.

The staff we spoke with told us how they supported people to make decisions and choices about their day to day needs. The people we spoke with confirmed this happened. However, the service was not always checking or assessing some people's capacity to make certain decisions. Even when there were possible signs that this needed to happen. People were being asked for their consent to share information with professionals and the local authority, but people were not being informed about what kind of information could or would be shared with these professionals.

People spoke positively about how caring and kind staff were towards them. Staff told us that they took practical action when a person needed further support and help.

Despite this, the provider and previous management of the service had taken certain actions which put people at risk. They had not considered people's needs and wishes. Therefore, the service as a whole was not always caring towards the people they were supporting.

People's assessments were not always person centred. People had only recently started to have reviews of

their care. People's reviews did not evidence if actions were taken when issues with people's care were identified. People did not have end of life plans in place even when this was relevant to their needs. The service did not have a system to ensure these needs were captured in some way.

People's complaints were not always well managed. This had improved recently but there were still areas where the service was not promoting people's rights when they wanted to make a complaint. Alternatively, people told us that when issues were identified with the office, action to resolve these issues were taken.

People told us that the care they received had improved recently. In terms of seeing regular staff at their agreed times. As a result of this people said that they would recommend the service to others.

There was no registered manager in place at the time of this inspection. 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. However, an application had been made when we inspected and there is now a registered manager in place.

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.

The service had not been monitoring if people had received their care visits. Some people had had missed care visits.

Risk assessments were not always complete. The accompanying care plans did not fully outline the support people needed.

Staff knowledge about safeguarding was not complete.

Staff recruitment checks were not complete.

Systems were ineffective to ensure people always had their medicines as prescribed.

When something went wrong lessons were not always taken from these situations. No robust systems were put in place to prevent incidents from happening again.

People had good environmental assessments.

Is the service effective?

Requires Improvement

The service was not always effective.

Systems were not always used to monitor and ensure people had effective care.

Staff were not given the opportunity to fully get to know people's needs before care visits started.

Staff competency checks were not evidenced and robust.

Staff knowledge was not being routinely checked.

People's capacity to make certain decisions was not being checked.

People were being supported to have enough to eat and drink.

Is the service caring?

Requires Improvement

The service was not always caring

The management and the provider had not always ensured that people's needs were met and they were safe.

People spoke positively about how caring the staff who supported them were.

People told us that staff were respectful and they promoted their dignity.

People said they were supported to be independent.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's assessments were not always person centred. People had only recently started to have reviews of their care.

Reviews did not evidence if actions were taken when issues with people's care were identified.

People's complaints were not always well managed.

People did not have end of life plans in place.

People told us that the care that they received had improved recently. In terms of them seeing regular staff at their agreed times.

Is the service well-led?

Requires Improvement

The service was not always well led.

Poor decisions had been made about how care visits were to be monitored which undermined people's experiences and put them at risk. The local authority intervened to correct this.

Provider audits were not effective at identifying the issues found at the service. Plans were not put in place to make improvements.

Internal audits were not established or effective at identifying quality issues and making plans to improve.

The service was not sharing with the CQC events which they must

do by law.

Improvements were being made as a result of the local authority input, but not by the provider. These improvements had not been embedded into the service at the time of the inspection.

Mayfair Homecare - Biggleswade

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 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 was the service's first comprehensive inspection. They had had a change in their registration with the CQC. The inspection was announced. We gave the service 48 hours' notice of the inspection. This was because we wanted people's permission to talk to them before we telephoned them. The inspection started on 19 June 2018 and ended on 21 June 2018.

The inspection team consisted of one inspector and an Expert-by-Experience. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance the Expert-by-Experience had experience of someone they cared for using this type of service.

Before the inspection we had been in regular contact with the local authorities' contracts team and safeguarding team. We asked them for their views on the service. They had concerns about the care people received and if people were safe. We looked at the notifications that the previous registered manager and the management of the service had sent us over the last year. Notifications are about important events that the provider must send us by law.

We had not asked for a Provider Information Record (PIR) as the inspection was arranged at short notice.

During the inspection we spoke with seven people who used this service, and three people's relatives. Six members of staff, the manager and two senior members of staff. We looked at the care records of four people, the medicines records and daily notes of three people. The recruitment records for three members

of staff. During our visit we also reviewed the systems and documents available to monitor the quality of the service.

Requires Improvement

Is the service safe?

Our findings

When we inspected Mayfair Biggleswade we spoke with the manager about people's needs and the risks which they faced. We found that the manager did not have a clear knowledge of the people who were most at risk. For example, by looking at a sample of four records we identified one person who had a significant breakdown to their skin. We had asked the manager if the service was supporting a person or persons who had a breakdown to their skin. They answered "No". This lack of overall insight into the most vulnerable of people had the potential to put people at risk.

We looked at a sample of four people's assessments. We found that the risks which people faced had been identified in their risk assessments. In some people's assessments particular risks were explored in detail. One person was unable to leave their bed, this person's risk assessment explained in detail how this person was to be supported.

Alternatively, we identified that some people's risks were not explored in detail. For example, one person had epilepsy. This person's assessment did not outline what the potential signs could be which indicated this person was about to have a seizure. Their assessment also did not say what type of seizures this person had. We spoke with a senior member of staff about this person's needs. They gave us detailed information because they had got to know this person over a long time. This person's assessment said that they had a seizure chart for staff to record when they had a seizure. This member of staff told us that this person did not have a seizure chart. We found no historical charts in this person's file. As information about this person was not recorded for staff to use as a guide to meet this person's needs, it was therefore unclear if all the staff who supported this person had the knowledge to meet this need.

People did not have detailed care plans which showed staff how to mitigate the risks which people faced. Although, we saw that people's care plans did contain some information to guide staff about meeting people's needs, there were often gaps in this information. Care plans lacked the step by step guidance about how to meet people's needs. For example, one person used a catheter. There was no information prompting staff about managing this need in the care plan. Another person was at risk of a further breakdown to their skin. The use of a skin cream is referenced in the risk assessment but not in the care plan. A further person's assessment said they administered a medicine themselves, however in their risk assessment it said they were to be prompted to take this medicine. It was unclear if staff were involved with administering this person's medicine or not. We spoke with the manager about this and they agreed it was unclear what staff's role was in relation to this medicine.

It is important that people's care plans contain detailed information on how to fully meet their needs. As the care plan is a tool to inform staff how to meet people's needs and to do so in a safe way.

When something went wrong, there was insufficient investigations and action plans developed to try and prevent incidents and accidents from happening again. A substantiated safeguarding event had taken place when a person was not being supported by staff to have a particular medicine, even though staff were

supporting this person with other prescribed medicines. Staff had not responded to the fact that there was a considerable amount of this medicine in this person's home. This person was unwell and vulnerable. There was no action taken after this event to check this was not happening in relation to other people the service supported with their medicines. Another person had run out of their medicines and did not have their medicines for two days. The management of the service took action to rectify this. However, they had not responded to the fact that the staff supporting this person, had not identified this person was going to run out of medicines. When we asked the manager and a senior member of staff about this we were told, "We don't get involved with ordering medicines." Despite this the manager had raised a safeguarding referral about the actions taken by the GP and the Pharmacy. They saw it was important to do this, but no action had been taken to try and prevent a similar situation from happening again.

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

During the inspection we looked at the recruitment practices for new staff. We looked at a sample of three members of staff personnel files. We saw that staff had two references, and disclosure and barring service (DBS) checks were completed. However, two out of the three recruitment files we looked at did not contain full employment histories for these new members of staff. The service's application forms asked for this information, but it was not consistently given. The management of the service were not checking if staff had any gaps in their employment history. One member of staff's application form stated that they were "Laid off" from a previous employer. Further information was not gathered about this. Another member of staff did not have proof of their identity. These are all important checks to ensure people are safe around staff. Especially, when people are often supported by a member of staff when they lived alone.

The above issues constituted a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had until recently not been monitoring if people had received their care visits. Two people told us that they had experienced missed care visits during this time. A missed care visit could undermine a person's safety. Without these monitoring measures in place the service was not promoting people's safety.

When we spoke with staff about how they protected people from potential abuse and harm, staff had a clear understanding of this. The six members of staff we spoke with told us how they would identify potential abuse. They also told us that they would tell the manager about their concerns. However, when we asked staff what outside organisations they could also contact only one member of staff said the local authority. They told us that they knew they could do this from the training from a previous job. Staff said they would go "Higher" in the organisation if they needed to, but they could not tell us who they would contact or how they would go about doing this.

From speaking with staff about their understanding about protecting people from harm, we identified some further shortfalls in knowledge. One member of staff said they would also record their concerns in people's communication book. This is not safe practice. This could also undermine a potential investigation by the local authority and police. Another member of staff told us that, they would not take further action if they believed the management of the service were not responding to their concerns about a person's safety. They said, "I can't take that sort of thing on myself." They clearly did not understand that protecting people from potential harm and abuse is everyone's responsibility.

We asked the staff we spoke with about their understanding of discrimination. Again, these members of staff had a very clear view of this. However, they had not considered if the people they were supporting were

more vulnerable to experiencing discrimination. For example, older people.

The local authority had shared concerns with us at the CQC about Mayfair Biggleswade. Care visits were not being monitored. People were not getting care visits when they wanted them. There was a risk that some people could have experienced missed care visits. These could be indicators that there was insufficient staff to meet people's needs. Without the monitoring of care visits the management of the service could not be certain that they had enough staff to meet people's needs. Due to the local authorities input the service was now monitoring care visits to ensure they were taking place as planned. We were shown how this was being monitored daily and during the evening. The service could now have assurances that they had enough staff to meet people's needs.

We considered how the management of the service supported people to receive their medicines as the prescriber had intended. We looked at a sample of people's Medication Administration Records (MARs). These were being audited and most errors were being identified. However, we saw one person's MAR where it stated that they should have a medicine at bedtime, but it had been administered in the morning. This had not been addressed. We spoke with the manager about this, who could not explain why this had happened. We also found two missing signatures on another person's MAR. When errors had occurred such as missed signatures, there was no clear investigation taken to check if the person had been given their medicine. There was also no detailed information as to how these errors were addressed to try and prevent them from happening again.

Alternatively, people told us that, staff supported them appropriately with their medicines. One person said, "It works very well and I've had no problems." A person's relative said, "It works well. The medicines are in a dosette pack and they give it to [relative]. It's then recorded on a sheet."

We concluded that further work was required for the leadership of the service to be assured that people were always receiving their medicines as prescribed.

The management of the service had a contingency plan to respond to emergencies such as a sudden loss of staff or to respond to severe weather conditions. However, when we looked at these plans some practical information was missing. For example, there was no information about which members of staff could be called upon in an emergency. How they would acquire other staff if the service found themselves with too few staff due to an emergency. Staff contact details were not in this plan. There was no evidence to show that this plan was shared with senior staff and that they understood what actions they needed to take or even where the plan was located. We concluded that further work was required to make this plan robust.

When we looked at people's care assessments we saw that the service was conducting good environmental risk assessments. This was to check that people and staff were safe when receiving and delivering care.

People told us that staff adhered to good infection control practices. Staff were able to tell us what these practices were.

Requires Improvement

Is the service effective?

Our findings

Mayfair Biggleswade had been asked by the local authority to use an electronic system to monitor the care visits which people had. This would enable the service to check people had received their care visit, and that the member of staff had stayed for the agreed time. This system would also allow the service to monitor if people were getting care visits at the times they had requested. However, earlier this year the then management of the service stopped using this system. The service was recording people had had care visits at times which they had not had. After the input from the local authority the service was now using this system, the management and provider said they would continue to use this system as a tool to ensure people had effective care. Given this recent history, more time would be needed to evidence the continued use of this system.

We spoke with staff about how they got to know people's needs. All five members of staff said they were told the basic needs of people over the phone. They also said that they briefly looked at the care plans. One member of staff said, "I'll have a quick look." Staff were not being given the opportunity to have a full debrief of a person's needs before they supported them. Staff were not looking at the risk assessments which generally contained more detailed information about people's needs than the care plans did. We spoke with the manager about this. They agreed there was not a clear system in place to ensure people's needs were fully known and understood by the staff who supported them.

The staff spoke positively about their inductions to their work. Staff received an induction which included face to face training in key areas such as moving and handling, medication administration, and safeguarding. Staff then shadowed experienced staff and there was a checking process that new staff were competent to work independently. Further e-learning training would be provided. Staff also completed the care certificate. This is a set of standards which outlines what good care looks like.

We were told by the manager and provider that this way of training was changing. As part of staff inductions, they would not have class room training, they would be taught some face to face training in people's homes by a senior member of staff. We asked the provider how they can be confident that the training from senior staff would be effective. They told us that they intended for the senior to be assessed a few times each year. This was to check that they were effective at delivering training. They intended to put this system in place later this year. However, there was no plan to test or check that this new type of training was effective.

During the inspection we were shown the training matrix. It showed that all staff had up to date training. This was monitored by the manager and provider. However, staff were not being given training in areas relevant to some of the people they were supporting. We identified that some people had long term conditions such as multiple sclerosis, epilepsy, diabetes, and acquired head injuries. Staff did not receive training in these areas. There was no system to check that staff had in fact retained the knowledge and understanding of certain training topics, sometime after they had completed this training.

Staff competency was assessed when staff completed their induction and the care certificate. However,

these competency assessments did not evidence how the assessor had reached their conclusion, that individual staff were competent in their work. There was no one assessing the competency of the assessor. Therefore, the management and the provider did not have firm assurances that these assessments were robust. Staff also had spot checks and we could see that these were happening on a regular basis. However, there was also a lack of evidence to show how the individual members of staff were competent in their work. Staff were not being asked what people's needs were and the possible risks which they faced. In order to check staff knew how to support people and keep them safe.

We spoke with the manager about these shortcomings. They sent us a revised form used to assess staff competency. However, there was no plan regarding the training of the assessor to ensure the assessment of staff was robust.

When we asked people about whether they felt staff were knowledgeable in their work, we had a mixed response. One person said, "I'm happy with the quality and they know what they [staff] are doing." However, one person said, "Yes, mostly, they [staff] know what they are doing, although some are better than others." A further person said that, "Their [staff] levels (of ability) vary."

People told us that staff supported them to have enough to eat and drink. One person said, "Yes, they [staff] help with lunch and everything's fine." Another person said, "Staff sort my food out and always ask me what I would like them to make for me." A person's relative told us that, "It all works really well. It's usually frozen meals, either pre-bought or things I've made for [relative]."

Staff told us how they ensured that people had enough to eat and drink. The staff we spoke with told us that they did not leave food out for people who needed support or encouragement to eat. Staff also told us that they supported people to eat their food and they checked if other people needed this assistance. Staff said they did this to ensure people had the support they needed with their food and drinks.

When we looked at people's reviews the service was not specifically checking or testing if people were supported appropriately with their food and drinks. This was not commented or checked at staff spot checks. One person had said that some staff were not making their food in a way which they liked. There was no action recorded on this review to show how this issue was resolved. We also looked at one person's care record who staff supported to eat. There was no guidance for staff to follow about ensuring this person did not choke when they were being supported to eat. Further work was required to monitor this element of the care being given to some people.

People we spoke with said they were confident that if they had a change in their health needs staff would respond to this. During the inspection we looked at people's communication books. This is information which staff recorded about people's needs and the actions they had taken to support individual people. We saw examples of staff calling people's GP's on their behalf or advising relatives about their concerns when a person's health needs changed. On one occasion we saw an entry that the office was called and a GP visit was to be requested. We later saw recorded that the GP had visited. However, we also saw an entry that a member of staff had said following this visit that the person was hungry but no food was given due to a particular health need. It was unclear where this advice had come from. It looked like this member of staff had made this judgement themselves. This communication book was audited but this issue was not identified and investigated.

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 saw in people's care records that they consented to the care they received. Three people out of the four care records we looked at had agreed for information to be shared with the local authority and GP's if required. Although, it did not stipulate what type of information could be shared. We also noted that in one person's care record their relative had signed their relative's consent to receive support from the service. This was not explained or justified in this person's care record. Another person was living with dementia, we spoke with a senior member of staff who said that this person can get, "Very confused." Despite this person having a cognitive condition and staff having this understanding no capacity assessment had been completed. Their recent risk assessment said that this person had capacity, but there was no evidence to say how this conclusion had been reached. We concluded that this person had not had a capacity assessment by the service regarding their ability to consent to care.

Staff told us how they encouraged people to make their own decisions about their daily care needs. The staff we spoke with had a good understanding about what capacity meant. People we spoke with said that staff did not make decisions on their behalf, but took their instructions from the individuals themselves.

We concluded that further work with consent and capacity assessments was required for the service to be complaint with the MCA.

Requires Improvement

Is the service caring?

Our findings

Leading up to the inspection we had been in communication with the local authority. They were aware that people were not getting care visits when people wanted them. They were concerned that some people had missed care visits. We were also informed of a substantiated safeguarding event made by a social care professional who had visited a person and found they had had a missed care visit. It took two hours for the office to send a member of staff to support this person.

As a result, of the local authority's involvement we could see that when we inspected the service improvements were being made to address these issues. Care visits were now being monitored. However, these were recent improvements. We could not be confident that these improvements had been sustained, at the time of this inspection.

These issues related to the management of the service. The fact this had recently happened questioned how caring the service was. People's needs and feelings were not put first. Action to correct these issues was prompted by the local authority not by the provider. As a result of these issues this area has been rated 'requires improvement'.

When we spoke with people they were positive about how staff treated them. One person said, "They [staff] always makes sure I'm ok before they leave." Another person said, "The girls always come in and say hi, how are you today. They will sit with me and chat, they are lovely." A person's relative told us that, "It's a general feeling that they [staff] are caring. I've got no complaints." A further person's relative said, "They [staff] are always nice and chatty and seem fine to me."

The staff we spoke with told us what practical action they had taken to respond to people when they were distressed. One member of staff told us that they contacted the office as they were concerned that one person was regularly distressed. They told us that the office contacted social services to arrange more social support for this person.

From the records we reviewed we saw one example of a member of the office staff taking practical action to respond to a person's request for assistance relating to their home. Although how this member of staff went about this was not recorded in this person's records. A person told us about a member of the office staff who had given them information to help them get out and about in their local area.

The staff we spoke with told us how they respected people's dignity and privacy when they supported people with personal care. The people we spoke with confirmed this. One person said, "They are always nice and polite." Another person told us that, "They [staff] are all very respectful." A person's relative felt confident staff were respectful, "Because of their [staff] politeness and manners."

When we looked through a sample of four people's communication records we saw that sensitive information was recorded in a respectful way.

The people we spoke with told us that staff supported them to be as independent as they wanted to be. One person said, "They [staff] help with the things I need help with, not what I can do for myself." A person's relative told us that, "They [staff] do what [relative] can't do."

Requires Improvement

Is the service responsive?

Our findings

When we spoke with people we asked them if they had care visits at their agreed time, and if they had experienced missed care visits. People told us that this had improved recently. One person said, "I've had some late calls in the past, but it's a lot better now." Another person said, "Usually it's fine." A person's relative told us that, "It's working well at the moment. [Relative] has got regular carers. In the past it was a bit up and down."

We also asked people if they saw a regular group of care staff. One person said, "Yes. They [staff] all know me." Another person said, "Yes. I've got regular carers." A further person told us that, "I've got quite a few (staff who support me) but I like them all and they've got to know me."
People's relatives told us that this continuity of staff had improved recently. Having a regular group of staff supporting people is important. It helps people to be comfortable with the staff who support them and enables staff to monitor and manage the risks which people face, more effectively.

Two people we spoke with had had a missed care visit this year. The manager told us about how rotas and staff deployment was being more effectively managed now than in the past. During our visit we heard two members of staff question their rotas. One person was not on their rota and another had been given a time they knew that the person did not like. Three members of staff told us that sometimes people were given times of care visits that they know they would not want. They told us that in these situations they alter their rota and they inform the office. Given the recent history we could see improvements in this area were being made. However, a longer period was required to fully embed these.

At this inspection we considered how complaints had been managed by the leadership of the service. We looked at a sample of complaints. These were not always complete. These records did not always show that the concerns had been fully investigated. When it stated that meetings were held with the complainant, these were not recorded or evidenced.

We looked at a recent complaint. We could see that the manager had responded to the issues raised. However, there was no information in the service's response to these complaints about what the complainant could do if they were unhappy with the outcome of the complaint or how it was handled. There was no reference to the local ombudsman. There was also no information about how to contact the ombudsman. We raised this with the manager, who was not aware of the role of the ombudsman in relation to complaints. A report had also been produced by the manager regarding a recent complaint to see if it had been resolved. Given the information in the report, it was clear that the issues had not been fully resolved. Despite this there was no real plan in place to revisit the improvements suggested to check these were happening.

Alternatively, people told us that when they had issues with the support they received outside of making a formal complaint, these issues were resolved. One person said, "Whenever I've contacted them [office] things have been sorted out." Another person said, "The only time I've contacted them, [office] was when

there was an issue with the timekeeping and it was sorted out satisfactorily."

We therefore concluded that improvements were being made in this area. However, further improvements were required and time was needed to ensure these improvements were embedded into the service.

People did not have end of life plans in place. There was no real consideration for this during the assessment process or later when people's care was reviewed. We were told about one person who had a diagnosis of a long-term condition and whose relative had informed the service that their relative was end of life. There was no plan in place, the process of having this conversation, had not begun, plans were not being made to do so, even considering the service knew this information. Staff were not being trained about how to plan for this potentially important part of people's lives. We spoke with the manager and provider about this and suggested they reviewed this area of people's care planning.

From looking at people's records we could see that the service had re-written people's assessments and care plans. We were told by the manager and the local authority that the previous records were not satisfactory. Positively we saw some examples that personal information had been captured to help to provide care which was personal to people. For example, in one person's assessment, who spent all their time in bed, the assessor had obtained what types of TV programmes they liked to watch. This was to assist the staff who supported this person to meet this need. However, other information was missing. The assessment had not tried to capture what people's interests were, their backgrounds, and achievements. We often saw comments such as "Likes most music" rather than particular types of music. When people were being supported with their meals often there was very limited information given here about people's likes and dislikes. This level of information is important as it helps the service promote people's needs and enable staff to get to know people.

People had only just started to have reviews of the care and support they received. This had not been consistently taking place before. We looked at these reviews and we could see that the service was asking questions to enable them to check people were receiving an effective service. However, when people raised issues during these reviews, it was not evidenced if these issues had been responded to. There was no follow up to check these issues had now been resolved. We explained the importance of this to the manager and provider.

Alternatively, when we spoke with staff who saw a regular group of people they said over time they had got to know the people they supported and formed good relationships with them. They said that this had helped them to provide more effective care to people. Some people also spoke positively about the regular staff who supported them. This was positive. However, improvements were required in people's assessments, care planning and in their reviews.

Requires Improvement

Is the service well-led?

Our findings

Concerns had been shared with us by the local authority about the leadership of Mayfair Biggleswade. As a direct result of these concerns the local authority had taken action. They started visiting the service on a regular basis and had various meetings with the provider and management of the service. The purpose of these visits and meetings was to support the service to make the necessary improvements and to check improvements were being made. The local authority confirmed that the current leadership of the service and the provider had been responding positively to this involvement and had been making changes to improve the service.

The provider had not recognised the issues of concern and taken action to rectify them before the local authority became involved in the service. This and what we found when we inspected Mayfair Biggleswade questioned how effective the governance systems were at the service.

We looked at the last provider audit in 2017. This did not consider if people were receiving care visits at the times they had requested, if people saw a regular group of staff, and if there had been any missed care visits. No consideration was given about how the management of the service was monitoring and checking these areas and if these systems used, were effective.

A further provider audit had identified that people's assessments and care plans were not sufficient. However, there was no follow up to check this had been rectified. The local authority identified this issue and has worked with the management of the service to make these improvements.

When we inspected we found short falls in people's care plans. They lacked some important information and step by step guidance for staff to follow. Some people's risks were not explored fully. Key information such as which GP surgery they were registered with and the contact details for their surgery were also missing. What information could be shared with other agencies was not clear. One person's capacity to consent to care had not been meaningfully explored. When reviews took place action to respond to issues raised during the review process had not been evidenced. People's records were not being checked by the leadership of the service to audit the information contained within them. Even despite the fact the provider and local authority had found issues with people's records. It was therefore unclear if the leadership was able to meaningfully audit people's records. Training by the provider had not been given in this area.

We could see that people's MARs were being audited but there was no evidence to show what action was taken to address issues and prevent them from happening again.

We found that staff personnel files did not contain full employment histories and one member of staff did not have proof of their identity. Staff competency assessments and reviews were not evidencing how these members of staff were competent. We needed to explain this to the manager. This is about the assurances the leadership and provider have that staff are able and effective in their work. These issues had not been identified as part of the provider or management audits.

The culture of the service had not been monitored or assessed by the provider. The provider's representative had aligned the issues with the service with the previous managers at the service. They had not considered the provider failings in identifying and addressing the issues that were found. This was not consistent with an open culture.

The leadership of the service were not routinely considering what improvements could be made when errors occur or something goes wrong. Complaints had not been historically well managed. The service was not signposting people to other agencies if they disagreed with the outcome or how a complaint had been handled. The service was not meaningfully testing if the complaint had been resolved and people's situations had improved.

The above issues constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The previous and current management of the service had not been notifying us about important events they should be doing so by law. For example, this included concerns relating to people's safety which the service was aware of. Recently the manager made a safeguarding referral to the local authority about a person the service was supporting. We were not notified of this.

The above issues constituted a breach of Registration 18 Regulations 2009 (Part 4).

There was not a registered manager at the service when we inspected the service. However, an application had been made at this time to the Care Quality Commission. A registered manager had been appointed after the inspection.

Despite all these issues people told us that their experience of care had significantly improved. Improvements were being made and the leadership of the service was working with the local authority to improve the service. However, these improvements were recent. Given the issues with quality monitoring from the management of the service and the provider, we could not be confident that improvements had been sustained at the time of this inspection.

We could see that the management of the service were trying to engage with staff. Meetings were being held and initiatives were taking place to encourage the staff into the office and gain their views of the service. However, a recent change had been made in terms of staff inductions. Staff had not been consulted with or involved in this decision.

There had been no attempts to involve the community or further involve the people the service was supporting in the development of the service.

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 Regulation 18 HSCA (Registration) Regulations 2008 (part 4): Notifications of other incidents. The provider had failed to notify the commission about all the important events they must notify us about by law. Regulation 18 (1) and (2) (e)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe Care and Treatment The provider had not ensured that care and treatment was always provided in a safe way. They had not assessed all the risks to people's safety or taken appropriate actions to mitigate these risks. Regulation 12 (1) and (2) (a) (b).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Well Led. There was a lack of systems and effective auditing of the service with appropriate action

plans put in place. There was also a lack of transparency with management of the service.

Regulation 17 (1) and (2) (a) (b) (c) (e)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 HSCA 2008 (RA) Regulations 2014: Fit and proper persons employed. The provider had not ensured that all staff employed had the appropriate pre-employment checks in place. Regulation 19 (3) (a).