

Mayden Support Ltd

Mayden Support

Inspection report

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20 April 2022
21 April 2022
25 April 2022

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Inadequate ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Mayden Support is a domiciliary care service that provides support and personal care to adults in their own homes. Not everyone who used the service received personal care. At the time of our inspection 20 people received support with their 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

During the inspection, we found that the provider had recruited a senior member of staff without following a safe recruitment process. This led to an unsafe appointment and placed people at potential risk. At the time of our inspection, this person no longer worked for the service. Care staff recruited by the manager had however been recruited safely.

Medication management was not safe. There were no adequate systems in place to check that people's medicines were administered as prescribed. Medication administration records were not accurate, and information relating to people's medication needs was not up to date or accurate.

People's needs and risks had not been adequately assessed and care plans had not been updated appropriately, when people's needs and visit preferences had changed.

People's visits times did not always correspond with the visit times they had agreed with the service. Visits were sometimes much later or earlier than agreed. Records relating to the length of time staff spent providing support to people, were also not accurate. This lack of accurate record-keeping made it impossible to tell if people's visits were occurring as planned in order to mitigate and manage risks.

The provider had a policy in place with regards to COVID-19. Staff testing for the virus at the time did not adhere to government guidelines in place at the time of the inspection.

There were limited systems in place to monitor and audit the quality and safety of the service. This meant they did not identify the concerns we found during the inspection. The manager and provider failed to have sufficient oversight of the service to monitor and mitigate risks to people's health, safety and welfare. The provider had also not always acted with respect for the duty of candour at all times.

People and their relatives said staff were kind, caring and supportive. They said that it was easy to get in touch with 'the office' to speak to someone if they needed to and that they were happy with the support they received from staff.

Rating at last inspection and update

The last rating for this service was good (published 01 October 2021). At the last inspection the domains of

safe and well-led were rated good. At this inspection, the domain of safe had deteriorated to inadequate and the domain of well-led to requires improvement. A breach of regulation 12 (Safe care and treatment), regulation 19 (Fit and proper persons) and regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified.

Why we inspected

We received concerns from the Local Authority in respect of the recruitment of a senior member of staff. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this report

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Mayden Support 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.

Please see the action we have told the provider to take at the end of this report.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner. We will work with the local authority to monitor progress.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not 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.

Mayden Support

Detailed findings

Background to this inspection

The inspection

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

Inspection team

This inspection was undertaken by two inspectors 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 service.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own homes.

The service had a manager registered with the Care Quality Commission. This means 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 the 20 April 2022 and ended on 25 April 2022. We visited the service location on 20 April 2022.

What we did before the inspection

We reviewed information received about the service since the last inspection. We liaised with the Local Authority Safeguarding Team with regards to the concerns raised by them in respect of the provider. We used all this information to plan our inspection.

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.

During the inspection

We spoke five people using the service and/or their relatives. We spoke with the regulated provider, registered manager and the care co-ordinator. We reviewed a range of records including five people's care records, a sample of medication records, six staff recruitment files and records relating to the management of the service.

After the inspection visit

Due to the impact of the COVID-19 pandemic we limited the time we spent on site. Therefore, we requested records and documentation to be sent to us and reviewed these following the inspection visit remotely. We continued to seek clarification from the manager and provider to validate evidence.

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 good. At this inspection, this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- Information about people's medicines and the support they required, was not up to date or sufficiently detailed to ensure medicines were given safely.
- The time people's medicines were given was not accurately recorded on their medication chart to ensure medicines were given as prescribed. For example, one person's morning medicines were due, and signed for, as given at 9am. Yet other records showed the actual time these medicines were administered was often up to an hour and a half later or earlier than specified.
- One person's medicines were secondary dispensed. This meant the medicine was removed by staff from its original container and left for the person to administer themselves later. This practice was not risk assessed and there were no written procedures for staff to follow to mitigate possible risks. Secondary dispensing is not a recommended or safe practice.
- Staff had no guidance on how to administer as and when required (PRN) medicines such as prescribed creams. Records showed that these medicines were not always applied consistently.

The management of medicines was not always safe. The systems in place to mitigate risks with the administration of medication were not robust. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks associated with people's care were not properly risk assessed or managed. Staff lacked adequate and up to date information on people's needs and the support they required.
- In some cases, people's rights were not respected in relation to risk management. This was not good practice. For example, one person's wishes in respect of their mobility care was not respected by staff. The manager told us staff were following the advice of the person's occupational therapist, but there was no evidence of this advice in their care file.
- Care records showed people's visits were often late or earlier than agreed in their care plan. The manager told us that sometimes people requested visit times to be adjusted. There was no evidence of these discussions and care plans had not been changed. This made it impossible to tell if people's visits were completed on time.
- Most people said staff stayed for the length of time needed to provide their support. People's records however did not reflect this. In some cases, visit records showed visits lasted less than 5 minutes. When asked, the manager said staff sometimes forgot to log in and out of visits and that the electronic system in use did not always work properly in some postcode areas. Despite this no adequate action had been taken to resolve this.

People's risks and care was not adequately assessed, monitored and managed to prevent avoidable harm. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- This inspection was prompted by local authority concerns over the recruitment and appointment of a senior member of staff. During the inspection, we found the provider had failed to ensure appropriate checks on the suitability of this person had been undertaken prior to appointment. This placed people at unnecessary risk. At the time of the inspection, this person no longer worked at the service.

The provider had not ensured robust recruitment procedures had been followed at all times to protect people from potential harm. This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We looked at the personnel files of five other staff members and found that appropriate pre-employment checks were completed by the manager to ensure they were safe to work with vulnerable people.
- The manager told us the service was currently experiencing staff shortages. A recruitment drive was underway. They told us they were helping out to cover these shortages along with the care co-ordinator.

Preventing and controlling infection

- The provider had a COVID-19 policy in place that gave guidance on the process to follow with regards to positive COVID-19 tests; use of PPE and basic infection control measures.
- There was a system in place to ensure staff completed lateral flow testing. However, the frequency of staff testing did not comply with government guidance, in place at the time of the inspection. We discussed this with the manager and provider.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong.

- Safeguarding, accidents and other incidents involving people using the service were properly recorded and investigated
- People told us they felt safe and well looked after by staff. People's comments included, "I always feel very safe with them" and "They're all such fun and lovely people. I feel like they're my second mum when they're here".

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 good. At this inspection, this key question has deteriorated to requires improvement. 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; Continuous learning and improving care

- The governance arrangements in place to audit the quality and safety of the service were not sufficient. The systems in place were poor and ineffective. They failed to identify the serious concerns with risk management, medication management, care planning, record-keeping and governance found at this inspection.
- The provider had two systems in place to plan and deliver people's care. A paper-based system and an electronic system, but the information on people's needs and the care did not match. There was little evidence that people's care records were audited properly to ensure they were up to date and accurate.
- There was little evidence that the provider had oversight of the service. and neither the manager or provider of the service were able to explain the failings of the service and why they had not been picked up and addressed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcome for people; 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 had failed to notify CQC of the local authority investigation into the recruitment and safeguarding concerns raised in respect of a senior member of staff. This did not demonstrate they had a clear understanding of their duty of candour responsibilities.
- People's needs, and care was not assessed or planned appropriately as and when changes occurred. This placed them at risk of inappropriate or unsafe care that did not promote good outcomes.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- People and their relatives told us for the most part it was easy to get in touch with "the office" if they needed to speak to someone about their care. There was however little evidence that any regular care reviews took place to ensure people's care continued to meet their needs
- The involvement of other health and social care professionals, or medical professionals in their care was not always evident in the records reviewed.

The governance arrangements failed to ensure people received safe, person centred care which mitigated risks to their health, safety and welfare. This was a breach of Regulation 17 of The Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

- People and the relatives we spoke with told us staff providing support were kind, caring and patient. One person told us, "The girls are amazing, we all have a massive laugh. Everything just feels so easy. They help me with personal care, helping me get dressed and they'll even tidy up".

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 | <p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The management of medicines was not always safe. The systems in place to mitigate risks with the administration of medication were not robust.</p> <p>People's risks and care was not adequately assessed, monitored and managed to prevent avoidable harm.</p> |
| Regulated activity | Regulation |
| Personal care | <p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The governance arrangements failed to ensure people received safe, person centred care which mitigated risks to their health, safety and welfare.</p> |
| Regulated activity | Regulation |
| Personal care | <p>Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed</p> <p>The provider had not ensured robust recruitment procedures had been followed at all times to protect people from potential harm.</p> |