Sevacare (UK) Limited

Mayfair Homecare - Farnborough

Inspection report

Chartwell House
183 Lynchford Road
Farnborough
Hampshire
GU14 6HD

Tel: 01252546600

Date of inspection visit:
19 March 2018

Date of publication:
20 April 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection site visit took place on 19 March 2018 and was announced to ensure staff we needed to speak with were available. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults and younger disabled adults. In addition to people living with dementia, sensory impairment, a learning disability or a mental health diagnosis.

The service was created in 2016 when the provider took over three separately registered domiciliary care agencies in quick succession and formed Mayfair Homecare – Farnborough. The service had initially been based at a different office, but has been registered at the current location since April 2017. The service provided care to 98 people. However, just prior to the inspection, the provider had taken on a fourth domiciliary care agency and on the day of the inspection site visit, they took over responsibility for the 76 people previously cared for by that agency and their staff. This inspection considered the care provided to the 98 people receiving care from the service prior to 19 March 2018.

The service has a registered manager who was also registered to manage a second of the provider's services. A full-time manager had been appointed for the service and they were due to commence work in April 2018. 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.

Staff had undertaken safeguarding training and relevant guidance was in place. Actions had been taken to improve the safety of people's medicines management as a result of safeguarding investigations. Further time was required for the provider to be able to demonstrate that all staff understood and had consistently followed their financial safeguards.

Risks to people had been identified, assessed and relevant measures taken to minimise the risk of occurrence for the person. Processes were in place to minimise the risk of people acquiring an infection during the provision of their care. Processes were in place to ensure staff were informed of changes required to people's care following incidents.

There were sufficient staff to provide people's care and the provider had taken action to hand back packages they could no longer accommodate. The staff files for those staff who had transferred into the provider's employment from the previous providers were not all fully complete. The registered manager has now audited these files and taken relevant action to ensure the required information is obtained.

Staff had undertaken work to ensure that people's medicine records were robust and that they contained sufficient information to enable staff to administer people's medicines to them safely.

People told us they received effective care. People's needs had been assessed including those whose care

had been taken on from the other providers. Processes were in place to ensure staff were updated and applied best practice in their work with people.

The provider had ensured that staff received an appropriate induction into their role and on-going training, support and supervision.

Staff had been provided with information about people's food and drink needs and preferences. Staff ensured that people had been left at the end of their care calls with food and drink within their reach where needed.

The service had worked co-operatively with partner agencies. People's records showed staff had worked effectively with a range of health and social care staff, to ensure people received well co-ordinated care. People had been supported by staff to ensure their healthcare needs had been met.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People told us staff had been kind and caring to them. People had been actively encouraged by staff to participate in decisions about their care. Staff had undertaken relevant training in relation to people's human rights and ensured people's privacy and dignity had been upheld during the provision of their care.

People received responsive care from staff who knew them well and understood their individual needs. People had been actively involved in planning their care and their care plans had been regularly reviewed with them. Staff supported people where commissioned to do so, to meet their recreational and social needs. Complaints had been actioned in accordance with the provider's complaints policy to ensure people's concerns were listened to and acted upon where possible. Staff were able to provide people with end of life care where required.

People told us they were very satisfied overall with the service provided, however, they would have liked more contact with management, to ensure they felt that they knew who managed the service. The registered manager and office staff had tried to get out and meet people, especially when they provided double up care calls with care staff. People's views on the service had been sought and action taken in response to their feedback.

The provider had taken action to engage and involve staff in the service. However, the location had experienced issues with the three pre-existing locations taken on to create this service. The provider and the registered manager recognised this and a lot of work had been completed to create a new entity and to lift standards. The existing registered manager would be supporting the recently appointed new manager during their initial months to complete this work.

The provider needed to be able to demonstrate that their processes for monitoring that all notifications had been submitted to CQC as required were sufficiently robust.

Improvements had been made to ensure people had robust care plans and medicine records. Processes were in place to audit and monitor various aspects of the service. It will take further time for the provider to be able to demonstrate that the medicine administration record audits introduced are effective.

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 consistently safe.

The provider needed time to be able to demonstrate that all staff had understood and adhered to their financial safeguards, to ensure people were fully protected against any potential risk of financial abuse.

Staff had assessed potential risks to people and appropriate measures had been taken to manage any identified risks to people.

There were sufficient staff to provide people's care. Measures had been taken to ensure that the required pre-employment information was available for all staff who had transferred to the provider's employment. It will take further time for the provider to be able to demonstrate these documents have been obtained.

People received their medicines safely from trained staff.

Processes were in place to minimise the risk of people acquiring an infection during the provision of their care.

Processes were in place to ensure staff were informed of any changes to people's care following incidents.

Is the service effective?

Good

The service was effective.

People's needs had been assessed and staff received updates about best practice to ensure people received effective care.

Staff were provided with the skills, knowledge and support to provide people with effective care.

Staff supported people where required to ensure they received sufficient food and drink for their needs.

Staff worked both within and across services to ensure people received effective care and support.

People had been supported with their healthcare needs.

People's consent to their care had been sought where applicable and legal requirements had been met where they could not provide their legal consent.

Is the service caring?

Good

The service was caring.

People told us staff treated them well and were caring.

People had been provided with relevant information to make decisions about their care and supported to express their views about the provision of their care.

Staff had promoted people's privacy, dignity and independence when they provided their care.

Is the service responsive?

Good

The service was responsive.

People received personalised care that had been planned and reviewed in co-ordination with them.

Staff supported people where commissioned to do so, to meet their social care needs.

Processes were in place to enable people to raise any issues about the service and these had been investigated and addressed for people.

Staff were able to provide people with appropriate end of life care where required.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a clear strategy for the delivery of the service and peoples' experience was that they had received good outcomes. People would have liked to have more contact with management, to ensure they felt that they knew who managed the service.

Work had been undertaken to bring staff together as a single service and this work was on-going.

The provider needed to be able to demonstrate that their processes for monitoring that all statutory notifications had been submitted to CQC as required were sufficiently robust.

People and staff had been engaged with the service.

The registered manager had ensured that quality assurance processes were in place and these had driven service improvements for people. However, it will take further time for the provider to be able to demonstrate that the medicine administration record audits introduced are effective.

The service worked co-operatively with partner agencies, to ensure people received well co-ordinated care.

Mayfair Homecare - Farnborough

Detailed findings

Background to this inspection

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

This inspection site visit took place on 19 March 2018 and was announced. We gave the service 48 hours' notice of the inspection activity to ensure staff we needed to speak with were available and to enable the service to inform people the inspection was taking place and that they may be contacted. Inspection activity started on 14 March 2018 and ended on 19 March 2018. We made telephone calls to people on 14 and 15 March 2018 and visited the office location on 19 March 2018 to speak with the registered manager and staff; and to review care records and policies and procedures.

The inspection team included two adult social care 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 care service. The expert by experience had experience of caring for older people.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events, which the provider is required to tell us about by law.

Prior to the inspection, we spoke to a social worker about the service. We sent questionnaires to 37 people of which 19 were returned, 37 relatives of which five were returned and two professionals of which none were returned. During the inspection, we spoke with 13 people and one relative. We spoke with five care staff, a care co-ordinator, the deputy manager, the care services director and the registered manager.

We reviewed records, which included six people's care plans and seven staff recruitment and supervision records, and records relating to the management of the service.

This was the first inspection of this service since it has registered at this location.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and that overall they received consistency in the staff who provided their care. They also told us staff stayed for the designated time of their care call. People's comments included, "I do feel very safe with the staff," "I have mainly the same staff quite often" and "We have consistent staff and they always stay for the allotted time, as per the contract." A person told us, "I didn't have the same carers at first but that has gotten better the longer the new people have been managing it."

Staff had undertaken safeguarding training and were able to demonstrate their understanding of their responsibilities. A member of staff told us; "Abuse could be things like unexplained bruising or bullying a person. My first priority would be to make sure the person was safe. I would speak to management if I had concerns and if needed; the police, social services or CQC." Staff had access to relevant policies and guidance, in the event they suspected a person had been abused. Records showed that the Local Authority had raised four safeguarding concerns with the service in 2017, three of which related to medicines. Investigations had been completed and actions taken since to strengthen medicines management for people.

The registered manager had recently made a safeguarding referral to the Local Authority. Following their investigation, a staff member should have been referred to the Disclosure and Barring Service (DBS), but this had not been done. Referrals should be made to the DBS when an employer or organisation believes a person has caused harm or poses a future risk of harm to vulnerable groups. The registered manager had sought advice, but had not checked the DBS website themselves for current guidance. They took immediate action following the inspection and made the referral. We noted this was the second time a staff member had not followed the provider's financial safeguards. We discussed with the registered manager whether in addition to individual actions, they had considered if any wider actions were required to safeguard people from the potential risk of financial abuse. They told us they had not, but that they would be re-visiting the financial safeguards with staff at the next staff meeting to remind them of the guidance.

Risks to people had been assessed in relation to for example, their mobility, skin integrity, diet, behaviours, medicines, worker safety and the home environment. Where risks had been identified, measures were in place to mitigate them. For example, if people had limited mobility, it was noted if any equipment was used to transfer them and the number of staff required to provide their care safely. Staff had been required to undertake moving and handling training prior to the provision of people's care. People's rosters demonstrated that where they required two staff to support them two staff had been rostered. Staff had been instructed to check the integrity of people's skin when they provided their personal care to ensure any issues were identified and addressed for them. People's records instructed staff to ensure people's property was left securely and that the person had a means of summoning assistance where required such as their mobile phone. Risks to people had been assessed and relevant measures taken to mitigate risks to people.

Processes were in place to enable the provider to assess their staff capacity daily to ensure all calls had been covered. Records demonstrated that 70% of people received consistent care from regular staff. The registered manager told us they had handed back some people's 'double up' care packages where two staff

were required to provide the person's care to the commissioning authority in the previous year. They handed back a further two in the week before our inspection, as they had lost staff and assessed that with five staff vacancies they did not have sufficient staff to provide these people's care safely. This had not been convenient for people, however, the provider had identified this as a safety issue and acted responsibly, whilst they sought to recruit additional staff. Staff told us that recruitment was challenging, and this had resulted in office staff who had received appropriate training having to facilitate care calls when they were unable to cover with them with the care staff. People's care calls had been covered; however, this had required additional support from the office staff.

Staff told us they had an interview before they started work. The registered manager told us they had commenced but not yet completed an audit of staff files, which records confirmed. We checked a file for a staff member recruited directly by the provider and it contained all of the required pre-employment information. Six of the staff files we reviewed were for staff who had transferred from the three companies the provider had taken over and their previous employers had completed their pre-employment checks. Full employment histories were not seen in all of these staff files. This was raised with the registered manager who obtained written explanations for gaps in staff employment histories. Following the inspection, the registered manager provided evidence that they had since completed their audit of the staff files for staff that had transferred. They had identified that a further two of these files only had one reference from a previous employer and provided an action plan detailing what actions they intended to take and by when to obtain the information. The associated risks were low, as these staff had already worked for the provider for a period of 18 months and formerly, for the previous providers.

The registered manager told us new DBS checks had been requested at the time of the takeover for all staff who had transferred from the previous companies. We saw that one staff's disclosure contained criminal convictions. The provider had spoken with them about this and completed a risk assessment. The registered manager informed us there had been no concerns with their conduct since they had entered their employment and provided evidence of peoples' positive feedback about them. Evidence from the provider stated the branch would have been informed that the staff member needed to be supervised and monitored. However, this was not explicitly stated within the risk assessment, which also did not demonstrate how the provider had concluded that the staff member was not a potential risk to people. We brought this to the attention of the registered manager, who following the inspection provided an updated and more robust risk assessment.

The registered manager told us a lot of work had been completed to ensure people now had robust medicine records. We saw that people had been consulted about their medicines needs and a medicines risk assessment had been completed. The provider had a specific risk assessment if people took Warfarin, a blood thinner, which has to be taken as prescribed. People's records included an up to date list of their medicines. If staff applied people's topical creams, there was a body map and written guidance to ensure staff had sufficient information to apply it safely. There was information for staff about who was responsible for ordering people's medicines, from where they were obtained and where they were stored. People's records noted how they could be supported to retain their independence with their medicines administration, for example, whether they needed staff to assist them with opening the packet for them. People received their medicines from staff who had undertaken relevant training in medicines administration. People received their medicines safely.

The provider supplied the care staff with protective equipment such as gloves and aprons so that risks associated with the spread of infection were minimised. The staff told us they had received training around infection control and that they had access to relevant guidance. The provider's records of staff observations included information about whether they followed infection control procedures.

Staff had been instructed in people's care records to report any changes or issues with their care to the office. Records demonstrated that where issues had been identified relevant action had been taken and people's care plans updated in order to keep the person safe. Staff were informed of changes to practice following incidents through staff memos and staff meetings.

Good

Is the service effective?

Our findings

People told us they received effective care. People's comments included, "The staff have proven that they have the skills to care for me," "They are skilled," "They are well trained" and "We've had them for years now, they are polite and they do always ask before giving care."

The needs of those people whose care had been taken on by the provider since the acquisition of the three previous companies had been re-assessed. This was in addition to the care needs of those people who had been new to the service. This ensured that each person had received an assessment of his or her care needs from the current provider.

The registered manager received updates about current practice from the provider, the local authority and CQC. They also attended registered manager meetings hosted by the regional manager in order to receive updates. In addition, the provider employed a quality assurance manager who attended seminars and forums and who monitored, recorded and acted on any changes in legislation, which was then reflected in the provider's policies and procedures.

Staff undertook an induction programme when they first began working for the service. This was centred round the Skills for Care Care Certificate and enabled staff to gain a thorough understanding of both working for the company and in a care environment. The Care Certificate is a set of standards that social care staff work towards in their daily working life. It is the minimum standard that should be covered as part of induction training of new staff. The induction consisted of policies and procedures, safeguarding adults, child protection, personal care, infection control, catheter care, pressure sore care, dementia, health and safety, emergency first aid, medication and safer moving and handling of people. The provider had ensured staff had the required knowledge and skills to support them to fulfil the requirements of their role. The staff training record confirmed that all staff were in date with all of their training. Staff told us they could also ask for training in areas that they felt they required more information on to support them in providing care to the people they cared for.

Staff had access to supervision as part of their on-going development. Care staff were provided with a supervision, an assessment, a spot check and an appraisal throughout the year. The care staff explained that the office staff observed them when they were providing care during spot checks to make sure they were doing everything right. The staff training record showed that the majority of care staff had had these completed as planned. Staff supervision records included a focus on working with other colleagues, any feedback from people, rotas, grievances, time keeping/attendance, standards of work and personal development. Staff had been appropriately supported within their role.

People's records stated what meals or drinks staff needed to support them with at each visit. There was also a record of what people's food and drink preferences were and any equipment they required to enable them to eat or drink. Staff had been instructed to ask people what they would like to eat for their meal. People's daily care logs documented both the food and drink people had consumed and what staff had left within reach for them to have later. This ensured people were not left without access to food or drink between

visits.

People's records demonstrated that staff had worked with commissioning agencies such as social services to obtain relevant information and existing assessments of people's needs to inform their care planning and risk assessments. If people had been admitted into hospital, staff had liaised with ward staff to re-assess people's needs prior to their discharge and worked alongside health care professionals such as occupational therapists to identify if people required any specific equipment to support them at home. Processes were in place to ensure that if people had a social worker, they were updated regards any changes to the person's care.

People's care records noted any health conditions the person lived with and the potential impact on the person, for example of a stroke. This ensured staff were provided with relevant information about people's health care needs. Staff were instructed to monitor people's health and to report any changes to the office. There was evidence staff had liaised with people's GPs for example where they had concerns about people's health. A person told us, "They take me to the doctors and other appointments and support me very well." People had been supported by staff with their healthcare needs.

Staff were aware of how to seek consent from people before they provided care or support and told us they would always ask before they provided care. Staff were also able to describe how they aimed to do this when delivering care. One staff member said, "Oh yes, they certainly don't do anything if they don't want to." Another said, "They always ask and definitely make sure it is what they want." Another member of staff commented, "If people are able to verbally communicate, they can tell you themselves."

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.

The staff we spoke with understood the principles of the MCA and gave examples of how they would follow appropriate procedures in practice. One member of staff said, "We get training in this area. If we are caring for somebody who is not able to make decisions then a best interest would be completed." Another member of staff said, "We must presume capacity initially, but if someone is really struggling with their own choices I would check with family first and work in people's best interests."

People's records noted if they had the capacity to make decisions in relation to how they wanted their care to be delivered. The registered manager told us all of the people they provided care for either had the capacity to consent to their care or had a power of attorney in place to make decisions about their care on their behalf. Therefore, they had not needed to assess anybody's capacity to consent to the delivery of their care. There was a copy of the power of attorney on people's records to demonstrate the legal authority of the attorney to act upon the person's behalf and in relation to what issues. Although no mental capacity assessments had needed to be completed, relevant documentation was available to guide staff through the MCA process and to document any decision made in a person's best interests.

Good

Is the service caring?

Our findings

People told us the service and staff that provided their care were caring. Their feedback included comments such as, "I know my staff and feel very well treated", "They're nice and friendly staff and we've gotten to know them." "The girls are more like friends now, and the care is second to none" and "They do always ask before they help me and they always knock on the door before coming in. I have confidence in my care." A relative told us, "[Loved one] has built relationships with [loved ones] carers and [loved one] is happy with the staff team and the care they provide."

Staff demonstrated concern for people's welfare and well-being. For example, a person did not require a care visit every day, but their records documented that on the days they were not visited, staff telephoned them to prompt them with an aspect of their self-care, which staff confirmed. People's care plans provided staff with details of how to ensure people's comfort, for example, when they transferred a person using the hoist.

The provider told us and the registered manager confirmed that at Christmas if people did not have a family staff had provided them with gift bags, which contained some festive food, and some small items personal to the individual to ensure people had received a gift. Staff cared about people and their welfare and well-being.

People's records told staff to consult with them about their care and to ask them what they wanted when their care was provided. Staff had also been instructed to document in people's daily communication logs, what choices people had made for themselves, to demonstrate their involvement. A person confirmed to us, "I am fully involved in my care and treatment. I still have all my marbles and like to know what is what." Another person said, "I feel involved in my care." People had been actively encouraged to participate in daily decisions about their care.

When people commenced the service, they had been provided with a copy of the provider's service user guide. They had also been provided with information about advocacy services, in the event they required assistance to represent their views. People had been provided with relevant information upon which to base decisions about their care.

People's care records documented their communication needs. If they wore glasses or a hearing aid due to sensory loss then this had been noted. People's daily communication logs demonstrated staff had ensured people wore these where required which ensured their communication needs had been met. People had been asked what their preferred language was and if they wanted information about their care to be provided in another language to ensure they could access information in a language they could understand. The provider had sought information about people's communication needs and ensured these had been met.

People's records noted their living arrangements such as if they lived alone and those close to them, this included the amount of contact they had with friends and relatives. This ensured staff had been made aware

of people who lived alone and whom might need more social interaction during visits and whom was important in the person's life.

Staff had noted how independent people wished to be and the tasks they wanted to undertake for themselves. Details had been provided for staff about other areas of people's lives they were independent in such as their work or travel. This provided staff with a picture of the person's overall level of independence, not just in relation to their care, which informed their understanding of the person as an individual. Staff told us how they assisted people to remain independent. One staff member said, "Many of our service users want to do things for themselves for as long as possible and our job is to ensure that happens. When someone can't manage to dress themselves any more without support, we encourage them to do as much as they can, even if it means taking a while." There was evidence that if people achieved greater levels of independence, then their care package had been reduced in size to reflect this change for the person.

Staff had undertaken mandatory training to ensure they understood human rights principles. People confirmed to us that staff respected their privacy and dignity when they had provided their care. A person commented, "They do respect our privacy and dignity." Another person confirmed "I do feel well treated, especially with privacy and dignity, they are very good like that." Staff ensured people had been treated with dignity and their privacy had been maintained during the provision of their care.

We asked staff how they aimed to treat people with dignity and respect when providing care. A member of staff said; "If a person is in the bath or shower, I will leave them to it if they are safe and they want some privacy. I would always ensure doors and curtains are closed as well when delivering personal care." A second member of staff said; "When supporting people to have a wash, I always make sure there is a towel covering the person. I always chat and make people comfortable. I want people to feel confident and talking keeps people preoccupied and focused on something else." Another staff member told us, "I treat people as if they are a family member. I ask their personal preference when providing care. If giving a person a full body wash, I cover people best I can with towels. I wouldn't want to be sat there with nothing on so why would they." Staff understood how to uphold people's privacy and dignity during the provision of their care.

Good

Is the service responsive?

Our findings

People told us they received their care from staff who knew them and that they had been involved in their care planning. People also told us they knew how to make a complaint if they needed to. Their comments included, "The staff know me very well. They are very receptive to my needs and cater to what I want from my care and support me well." Another person said, "I have a detailed care plan and I've always found them very accommodating if I want to change anything." A third person told us, "They went over everything when we first started having care from them."

People had an individualised support plan written in the first person, which detailed their care needs, preferences and desired outcomes from the provision of their care. For example, people had been consulted about their preferences for either male of female staff and about when they wanted different aspects of their care provided, such as their hair care. People's hobbies and interests had been noted, which provided information for staff about the person to enable them to initiate conversations with them. People had been involved in the planning of their care, which reflected their needs and preferences as an individual.

People had their care reviewed with them and relevant others regularly. Staff had checked if there were any changes required to people's information or risk assessments.

People's records demonstrated that their care had been increased or decreased where required in response to any changes in their needs. The service had been responsive to changes in people's requirements.

Staff had been provided with written information about what care they were to provide to the person at each scheduled visit, this ensured that the care provided was tailored to the person's needs at that particular time of day. Staff were instructed in people's care records to check the person's daily communication logs for any updates they needed to be aware of before they provided their care. This ensured they were aware of any relevant changes for the person that might impact upon the delivery of their care.

Where the service had been commissioned to meet people's social or leisure needs, this had been noted and how these needs were to be met with people, for example; whether the person required support with shopping, finances or activities and when this was to take place. People's daily logbooks documented the care provided to people and showed they had regular social interaction from staff during their care call.

The service ensured that people had access to the information they needed in a way they could understand it and complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The provider had identified if people had any communication needs for example due to sensory loss. People's records demonstrated they had then been consulted about whether they required information to be provided in large print or a pictorial format to meet their needs.

When people commenced the service, they had been provided with written information about how to make a complaint and this information had been verbally discussed with them, to ensure people understood the process. People confirmed they knew how to make a complaint. One person commented, "I do know how to complain, they went over it all, but it's only ever been very minor issues really."

There was a central record of the complaints received with the details of the actions that had been taken in response for people and these were reported to the provider. There was also written evidence to demonstrate that if people had made a verbal complaint about their care then this had been noted and addressed for the person. Two complaints had been received in 2018 and eight in 2017. Complaints had been actioned in accordance with the provider's complaints policy to ensure people's concerns were listened to and acted upon where possible. The provider had identified that within the last year a number of complaints had been due to their having to hand back care packages due to staff shortages, in order to make the service safe for people. Their focus in response to this therefore, had been on staff recruitment.

The service had also received a high number of compliments from relatives of people that used the service. Comments included, "I would like to take this opportunity to thank all the staff who cared for my father over the last few years, keeping him company, happy and comfortable. We really appreciate it. Keep up the good work." Another wrote "I wanted to write to you on behalf of my mother and our family to express our heartfelt thanks for the devotion, care and support you have given my mother over the last couple of years. For anyone consistency of care is important but I believe especially so for someone, like my mother who is 101 years old."

The registered manager told us that no-one currently required end of life care. However, this had been provided where needed previously for people and staff had access to relevant training to enable them to support people at the end of their life in co-ordination with relevant healthcare services.

Requires Improvement

Is the service well-led?

Our findings

People told us they were very satisfied overall with the service provided. Their comments included, "I'm happy with the company" and "It's a very reliable company. If they are honest, which they all seem to be, then I am very happy." People confirmed that they had been consulted about the quality of the care provided. A person told us, "I've filled in the forms twice and yes, everything is to my satisfaction." The only issue people raised was that they did not always feel that they knew the manager of the service. One person commented, "The only manager that I have ever met is [staff member]. I have never met any of the new managers either by visit, phone or in person. I've not seen a soul, and that is a disappointment." Other comments included, "I don't think that we've ever had any dealings with the management?" and "I'm not sure who the manager is?" People were of the view that they would have liked to have had more contact with management.

The provider's Statement of Purpose for the service set out their aims and objectives for people in the provision of their care. These were to provide high quality services that met people's expectations. Feedback from people indicated that their expectations had been met by staff.

The staff we spoke with told us they enjoyed working for the service and that there was an open, positive culture. One member of staff said, "It's definitely a good company to work for and has a good ethos." Another member of staff said, "I like working for Mayfair it's nice. The office staff are friendly and are very supportive. It's nice knowing that you are never alone, they are just a phone call away." A third member of staff also added, "I have worked here for nine years which I think says a lot. It's a good care agency to work and I enjoy my job." Staff told us that they had "opportunities to voice their opinion" and raise concerns informally and more formally through supervision and team meetings. People and staff were happy with the service.

The registered manager informed us that when the provider had acquired the original three domiciliary care agencies, there had been issues. People's care records, risk assessments and medicine records, had not all been of the required standard and in addition, there had been poor staff morale. The provider had identified and recognised the difficulties at the location and the need for strong management. They had placed the current registered manager in post who was very experienced a year ago. The registered manager had taken on the service in addition to managing their existing service, so their time had been divided between the two locations. There was also a full-time deputy manager based within the service, to support them with the day-to-day running of the service. The registered manager felt well supported in their role by the provider's senior management.

The registered manager told us they had made a significant number of improvements to the service and we saw evidence of this in relation to people's care plans, risk assessments, medicine administration records and staff training and supervision. However, they felt that to move further forwards the service required a full-time manager. The provider had made an appointment and a new manager was due to commence work on 23 April 2018, with on-going support from the existing registered manager until the provider had satisfied themselves of their suitability.

Although people felt that they would have liked more management contact, to ensure they felt that they knew who managed the service. The registered manager told us that they and the other office staff regularly undertook the provision of people's care, records showed this was often as the second worker on a 'double up' call. This provided them with both the opportunity to get out and met with people as they provided their care in addition to an opportunity to have further oversight of the quality of the care provided to people by staff as they worked alongside them. The registered manager and office staff had tried to get out and meet people.

The registered manager had correctly made a safeguarding referral to the local authority in February 2018; however, they had not submitted a statutory notification to CQC to inform us of this as legally required. We spoke to the registered manager who was unsure why this oversight had occurred. This oversight had also not been identified through the provider's monitoring of the service. Following the inspection, the registered manager immediately submitted the notification as required. Although they took action once this was brought to their attention, further time is required for the provider to be able to demonstrate that their processes for monitoring that all notifications are submitted as required are effective.

People's views on the service had been sought at their care reviews, when they had been asked for their views on: the service, staff attitudes, staff competency, staff efficiency and staff timing. People's views had also been sought through the annual 'User Satisfaction Survey', which people had completed in April 2017. The results demonstrated people were satisfied with the quality of the care provided. There was an action plan to address the one area identified for improvement, support from office staff. As a result, a meeting had been held with office staff to look at how they could improve their communications. This action had been monitored and records demonstrated this aspect of the service had improved since people completed the survey. The registered manager also informed us that this year they intended to introduce service user forums as an additional method to seek people's views and to involve them in the service. In addition, they were looking to build links with the community and had arranged a meeting with a local nursing home to discuss how they could engage with them for the benefit of people.

There was evidence that staff meetings had been held to enable staff to express their views on the service and they had been sent memos to update them on changes and new information. In addition to staff meetings, reviews had taken place of staff pay and 'Carer of the Month' awards had been introduced to boost staff morale.

The registered manager told us their focus had been on ensuring that people's records were complete and robust including their medicine records. We saw evidence that people's care records had been audited for completeness by 1 February 2018. People's care and medicines we reviewed were in good order and robust. Other aspects of the service which were now audited included people's daily communication logs and medicine administration records (MAR's), in addition to staff practice through observations. We noted that although staff who audited the MARs monthly had identified issues such as missing staff signatures, which the registered manager told us had been addressed; the auditor had not always documented the action they had taken, in order to demonstrate this had been completed. We brought this to the attention of the registered manager who took action following the inspection to address this. It will take further time for the provider to be able to demonstrate that the MAR audits are effective.

The registered manager completed a weekly report for the provider, which covered areas such as: care provided, staffing, complaints, risk assessments, quality monitoring and training. In addition, the registered manager and senior management had frequent oversight of key indicator matrixes for people and staff; these covered areas such as care plan reviews, risk assessments, calls allocated, staff training and staff supervision. These colour coded checks flagged up any outstanding work to be allocated and completed.

For example, staff could not be allocated to care calls if their training was out of date. Processes were in place to monitor the quality of the service provided and to drive improvements.

The service worked co-operatively with a range of partner agencies and professionals such as GPs, district nurses, social services and hospital staff to ensure people received well co-ordinated care. The service also worked with commissioning agencies contract monitoring processes. For example, a care call monitoring system was used with people's permission to enable the provider to monitor the timing and duration of people's care calls for them. The service had worked with a range of agencies to provide people's care.