Maycare Limited

Maycare

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Maycare provides domiciliary care services to people living at home. They currently provide a total of 1000 hours of personal care to 96 people. Each person received a variety of care hours from the agency, depending on their level of need.

The inspection was conducted between 1 and 13 December 2016 and was announced. We gave the provider 48 hours' notice of our inspection as it was a domiciliary care service and we needed to be sure key staff members would be available.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection we made two recommendations. These related to way staff monitored people's nutritional needs and the training staff received in supporting people who are living with dementia. At this inspection, we found the service had acted on these recommendations.

However, we identified fresh concerns that compromised people's safety. Pre-employment checks, to make sure staff were suitable for their role, were not always completed before new staff started working at Maycare. There were not always enough staff to meet people's needs at the time they required support, particularly at weekends, and staff did not always stay with the person for the allocated length of time.

There were no plans in place to deal with foreseeable emergencies, such as extreme weather. The system used to check staff had arrived at each call was not robust and did not protect staff who worked alone. However, the provider had tested the use of technology to assist with this and was researching the use of other solutions to monitor staff attendance at calls.

People told us their regular care staff were skilled at supporting them and meeting their needs. However, they said fill-in staff, who covered when their regular care workers were absent, were not always able to provide them with effective care and support.

There was a training programme in place. However, the induction procedures did not follow the standards of the Care Certificate (a learning programme designed to enable staff new to the role to provide safe and compassionate care to people). Also, there was no clear process in place to check that new staff were able to support people safely and effectively, for example when administering their medicines.

Staff felt supported in their role by their managers, although arrangements for one-to-one meetings to discuss their progress and raise concerns with managers were ad hoc and not organised.

The provider did not have a duty of candour policy to help ensure staff acted in an open and honest way when people were harmed. Not all of their policies and procedures were up to date or reflective of the type of service they provided.

The quality assurance procedures had brought about some improvements, but were not always effective in identifying and addressing improvements to the quality and safety of the service. Spot checks to assess the performance of staff were not conducted regularly. However, staff were happy and motivated in their work and described managers as "supportive" and "approachable".

Staff understood their safeguarding responsibilities and knew how to prevent, identify and report abuse. The care manager conducted effective investigations into allegation s of abuse. Risks relating to the environment or the health and support needs of people were assessed and managed effectively.

Staff were caring and compassionate. They took care to be discreet and unobtrusive when working in people's homes. They protected people's privacy, involved them in decisions about their care and developed positive relationships. Staff also followed legislation to protect people's rights, by seeking consent from people before providing care and support.

Most people's meals were prepared or provided by family members. However, staff encouraged people to maintain a healthy, balanced diet based on their individual needs and preferences.

Care plans provided appropriate information to enable staff to provide care in a consistent way. Staff responded promptly when people's needs changed and referred them to healthcare professionals when needed. People were encouraged to remain as independent as possible.

There was a complaints procedure in place and most complaints had been investigated and responded to appropriately. The provider sought feedback from people and their families and had developed an action plan to address concerns raised.

We identified several breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Recruitment procedures were not robust and essential pre-employment checks were not always completed before staff started work.

There were not always enough staff deployed to meet people's needs at the time they were required. Staff did not always remain for the allocated time.

The service was in the process of identifying ways to monitor whether staff had arrived at calls or to protect the safety of lone care workers. There were also developing plans to deal with foreseeable emergencies.

People trusted staff and staff knew how to identify, prevent and report safeguarding concerns. Effective safeguarding investigations were conducted.

People were supported appropriately to take their medicines, although the process used to assess staff competence was not consistent.

People were protected from individual risks in a way that supported them and respected their independence.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff who supported people regularly did so effectively, but fill-in staff were not always able to meet people's care and support needs.

Staff received appropriate training and were supported in their role by managers. However, there was no clear process in place to assess the competence of new staff and 121 sessions of supervision were not held regularly.

Staff protected people's rights and sought consent from people before providing care or support.

People were encouraged to maintain a healthy, balanced diet and to drink often. Staff monitored people's health and supported them to see doctors or nurses when needed.

Is the service caring?

Good

The service was caring.

People's regular care workers treated them in a kind, caring and compassionate way and built positive relationships with them and their families.

Staff protected people's privacy and dignity at all times.

People and relevant family members were involved in planning the care and support they received.

Is the service responsive?

Good

The service was responsive.

People's regular care workers delivered personalised care that met people's individual needs. Care plans contained information to support staff to deliver care in a consistent way and were reviewed regularly.

People were encouraged to remain as independent as possible.

The provider sought feedback from people and had developed an action plan to address concerns raised.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service did not have a policy in place to help ensure staff acted in an open and honest way when people came to harm. However, the provider did notify CQC of significant events and their previous performance rating was displayed as required.

Not all policies and procedures were up to date and some did not reflect the service provided by Maycare.

There was a quality assurance process in place, although this was not always effective in monitoring and improving the service.

Most people were satisfied with the service provided by their regular care workers. Staff were happy and motivated in their work.

Maycare

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.

The inspection took place between 1 & 13 December 2016. It was conducted by 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. The expert by experience was used to conduct telephone interviews with people and their relatives.

We gave the provider 48 hours' notice of our inspection as it was a domiciliary care service and we needed to be sure key staff members would be available. The inspector visited the service's office on 1 & 2 December 2016 and spoke with additional people and relatives, and staff, by telephone between 5 & 13 December 2016.

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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with five people who used the service and eight relatives by telephone. We visited and spoke with four people and their relatives at home. We spoke with the registered manager, the agency's care manager, two care coordinators, the financial administrator and 13 care workers. We looked at care records for six people. We also reviewed records about how the service was managed, including staff training, recruitment records, quality assurance audits and complaints.

Requires Improvement

Is the service safe?

Our findings

People receiving the service were not protected from the risks associated with unsuitable staff being employed by Maycare. Providers are required to undertake pre-employment checks, including with the Disclosure and Barring Service (DBS), to satisfy themselves that staff are of good character and suitable to work with the people they would be supporting. An enhanced DBS check will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

We identified staff who had been recruited within the previous year who had started work prior to their DBS certificates being received or confirmation that they were not on the barred list. The care manager told us these staff would only have worked alongside existing staff and would have been supervised at all times. However, two staff members told us this was not the case and they had supported people without any supervision. The registered manager accepted that they had previously allowed staff to work with people prior to their DBS certificates having been received, but told us they had taken a decision six months ago not to do this. This was confirmed by the provider's recruitment policy, which required staff to undergo an enhanced DBS check before starting work. The person responsible for recruiting staff was not available at the time of the inspection, so they were not able to explain why this was happening.

The failure to operate safe recruitment procedures, and ensure that all staff were of good character prior to being employed, was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always enough staff deployed to meet people's needs at the time they needed support. People told us that during the week they usually received a good service, but said the service was not always reliable at weekends, or on days when their regular care workers were not available. One person told us, "The weekends are worse than ever. Last weekend [staff] were late. I had to phone the office and they had to send someone. It was 10:00am in the end. When I phoned, they told me the [care worker] had gone sick, but they didn't call to let me know." Another person said, "Occasionally I get breakfast and lunch at the same time as the morning call is so late." A family member said, "At the weekend, [my relative] has still been waiting for breakfast at 10.30 am, which is a later time than planned for." Another family member told us, "The carers themselves are brilliant; but it's just the timeliness. I did complain to office this morning as this weekend was really, really bad."

People and their relatives told us the schedules they received, detailing the times and staff members who would be visiting to support them, were not always accurate. A family member told us, "We get [schedules] in advance, but the call times [when staff actually visit] often do not reflect the times on the schedule and the carers are often different from those allocated." Staff arriving late had a clear impact on people. For example, one family member said, "If the carers are late in the morning, [my relative] can be agitated. If he is left waiting and waiting, he will become distressed and be angry and shouting." Another family member told us, "[The impact of late calls] is a lack of dignity as [my relative] can't use the commode on her own and accidents happen. She finds it really distressing; it reduces her to tears sometimes."

Some staff were also critical of the scheduling of calls. One staff member told us, "The structure is poor. I had six calls all at the same time, one of which was an hour long. I contacted the office and they told me to sort it out with the [staff member] I was working with. I invariably have clashes in my rota." Another said, "There's quite often four calls at the same time, so I just work it around what I know people would be happy with. But sometimes it's really tricky. Yesterday I had four calls at 4:30pm; two calls at 5:00pm and five at 8:00pm. I called ahead to one person to say I was running late; she said staff had been late three nights in a row." A third staff member added: "It's manic at weekends and we get [scheduling] conflicts all the time."

Some people told us staff did not always stay for the full length of time that had been allocated and paid for because they were too busy. One person said, "[Staff] can't stay for the full time as they have so many of us to do. Sometimes they stay for 10-20 minutes in the morning, instead of the half hour they are supposed to do." A family member told us, "Carers don't stay the full time. [My relative] is only getting 20-25 minutes, but Maycare get paid for 45 minutes." Another family member said, "[My relative] gets an hour [allocated] at bedtime, but [staff] are often gone after 10 to 15 minutes."

The care manager told us staffing levels were determined by the number of people using the service and their needs. However, they accepted that weekends were "notoriously difficult and never run on time as [staff] take time off or go sick".

The failure to ensure sufficient staff were deployed to meet people's needs at all times was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's policy relied on staff following their rotas and people calling the office if a staff member had not arrived to support them. This was not robust and put people at risk of not receiving the necessary care, as some people lived alone and would not have the capacity to contact the office if the staff member did not arrive. In addition, the policy did not help ensure the welfare of staff who worked alone, as supervisors could not check that they had arrived and left each call safely. The provider's lone worker policy was very brief and did not provide practical advice or guidance to help staff to remain safe. We discussed this with the care manager, who told us they had tested the use of two technological solutions to monitor staff attendance at calls, but neither had been effective or compatible with other systems they used. They were currently exploring alternative options. As an interim measure, for two people who were particularly at risk, a system had been set up for staff to text a family member when they visited the person. If the family member did not receive a text, they could then alert office staff to take action. Following the inspection, the registered manager informed us they were introducing a 'traffic light system' to identify other people at risk who might benefit from a similar approach.

There were no plans in place to deal with foreseeable emergencies. The provider had not developed procedures to deal with adverse weather or disruptions to the communication systems. They had not assessed which people had family members who could support them in an emergency and which people lived alone and would be at high risk. They had not mapped out the addresses of staff to help identify which people they might be able to visit on foot if the roads were impassable due to snow. They had not explored the availability of 4x4 vehicles that could be accessed in adverse weather. We discussed this with the care manager who told us they had recognised the need for a plan and were in the process of developing one.

People benefited from a service where staff understood their safeguarding responsibilities and protected people from the risk of abuse. One person told us, "I feel safe with the care they give."
A safeguarding policy was in place and staff were required to complete safeguarding training as part of their induction. This training was then refreshed yearly. Staff were knowledgeable about the signs of potential abuse and the relevant reporting procedures. For example, we saw an example of a referral to the local

safeguarding authority following a medicines error. An investigation was conducted and action was taken to reduce the likelihood of a recurrence. A staff member told us, "I've not had any safeguarding concerns, but if I did, I would raise them with office. I'm confident they would do the right thing." Staff were also aware of external support they could access, if needed, including the local safeguarding authority and the Care Quality Commission.

The care manager conducted effective investigations into allegations of abuse. Four people had experienced a suspected theft of cash from their homes and told us the care manager was supporting them appropriately during the police investigation. The care manager had also used the provider's disciplinary procedures, to protect people from the risk of further loss, until the investigation could be concluded. Another person had raised concerns about the way a staff member supported them with personal care, and the care manager took appropriate action by deploying a different staff member to support the person. Following another investigation, the care manager had identified the need for improved communication to encourage staff to report concerns more promptly. We were shown a copy of a memo that had recently been sent to all staff to emphasise the importance of doing this.

Where people required assistance to take their medicines, family members confirmed that these were managed and administered safely. One family member told us, "[Staff] assist [my relative] with medicine; they will stay and see she takes it." For some people, the help required was limited to verbal prompting to take their tablets; for other people staff needed to administer medicines to them, for which they had received appropriate training. Following the training, senior care staff assessed the competence of the staff member to administer medicines on their own. However, the procedures used for the assessments were not consistent and in some cases there were no records to confirm that new staff were competent to administer medicines. We discussed this with the care manager who agreed to clarify and tighten up the procedures for this.

People were protected from individual risks in a way that supported them and respected their independence. For example, one person told us, "I have had falls before and that makes me worried about showering. On a Saturday morning I have a male carer which I asked for. He will stand by the bathroom door when I have a shower, so I can take it in privacy. I know he is there if I feel worried I might fall. Once I dropped my shower brush and it made a noise; he was in there like a flash to check I was alright. He makes me feel confident and safe."

Supervisory staff completed assessments to identify any risks to people using the service or the staff supporting them. These included environmental risks in people's homes and risks relating to the health and support needs of the person. When risks were identified, people's care records detailed the action staff should take to minimise the likelihood of harm occurring to people or staff. For example, staff were given guidance about using moving and handling equipment, alerted to trip hazards in and around the person's house and the safety of electrical appliances. Other people spent most of their time in bed and were at risk of developing pressure injuries; appropriate measures were being taken to reduce these risks, including regular turning and the use of pressure-relieving mattresses. Where people had come to harm, lessons were learnt. For example, an incident had occurred when a person's cooker had been left on and they suffered smoke inhalation. When we spoke with staff, they were aware of the incident and told us of extra precautions they now took when using people's cookers.

Requires Improvement

Is the service effective?

Our findings

People told us their regular care staff were skilled at supporting them and meeting their needs. For example, one person said, "They know what I need and know my routine well". Another person said, "I'm very happy [with my care workers]; I can't fault them." A family member said of the staff that were with them, "These girls are the top of the list. I couldn't fault them in any way. They know exactly what they're doing." Another family member said, "The [care workers] are brilliant. The personal care is perfect we can't fault them."

However, family members felt that the care workers who filled in for their regular staff member were not always able to provide effective care and support to their relatives. A family member said, "[Non-regular staff] don't know how to handle [my relative] when they move him. When they change his continence pad, they never get it on right, so it leaks and then we have to change the bed." Another family member told us, "If the carers are not [my relative's] regular ones, they will not know how to deal with her and they end up calling me. I have asked they try not to do this, but it doesn't seem to make much difference. This can be worse at weekends; it's frustrating. We got care so we wouldn't have to worry about [my relative] and now we worry about the carers sometimes."

A further family member said, "My [relative's] care is quality; first class Monday to Friday and Saturday morning. But the care at the weekends is not as good; Saturday tea-time and Sunday is hit and miss. I dread Sunday's coming round now." They then provided examples of how this affects their relative, including: "The main carer will sit and talk to [my relative] at mealtime to ensure he eats; others will 'plonk' food on a plate and leave it. [My relative] will forget and won't eat"; "[My relative] wears incontinence pads. They need to be checked. If he gets asked if they need changing he will say 'No'. Non-regular carers will leave it at that. I have found him in wet, sodden clothes after the carers have been"; and "With non-regular carers there seems to be a lack of understanding of dementia. [My relative] lost his wife in March. He forgets and will call out for her; he can shout at the carers not to go upstairs and disturb her. The ones who know him will take time to chat and comfort him, then go upstairs because they need to check and change the bed. Others will just leave it and I have gone to find the bed not changed and wet".

The failure to ensure that the care and support provided was appropriate and met people's needs at all times was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a training programme in place for staff and they received a financial incentive for keeping up to date with their training. A staff member told us, "I found the training really good." Whilst most training was completed via DVDs, practical subjects, such as moving and handling, were conducted in a training room that had been created in the service's office. This allowed staff to practise techniques used for supporting people to move, including the use of a hoist. A family member told us, "[My relative] needs help to move and [staff] have to use a hoist and they have been trained to use it." A staff member told us, "[The care manager] did an assessment of me at [the house of the person I support], watching me use the equipment to make sure I was using it properly." During a visit to a person in their home, we observed two staff members using the hoist competently and in accordance with best practice guidance. An additional DVD training module in

dementia care had been purchased by the agency and this was being tested by 10 staff to assess its effectiveness.

New staff received induction when they started working at the service. The care manager told us staff then worked alongside experienced care staff until they felt confident, and had been assessed as competent, to work unsupervised. However, there was no clear process in place to assess their level of competence and any further support they might need. In most cases, the staff member they had been working worth appeared to have made the decision, but this was not recorded and there were no clear criteria they had used for the assessment. In addition, there was no process in place to ensure that staff who had not worked in care before were supported to complete training that followed the standards set out in the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. We discussed the training and assessment of new staff with the care manager, who told us they were in the process of enrolling new staff onto a Care Certificate programme.

Most staff felt they were supported appropriately in their role. For example, one staff member said, "I wasn't confident [when I started] and if it wasn't for the support I got from the office and [the registered manager], I wouldn't be here today. Now I feel I could support any client." Another staff member told us, "I go in every year and have a supervision to make sure I'm happy and if I need any extra training." Other staff said they were able to visit or telephone the office at any time to seek support from the care manager or the registered manager. Staff received occasional one-to-one sessions of supervision and an annual appraisal. These provided an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. However, records showed that the frequency of supervisions was sporadic, with most staff only receiving one supervision and one appraisal over the course of a year contrary to the provider's policy which said they should be held four times a year. We discussed this with the registered manager agreed that the arrangements for supervisions were "ad hoc" and were an area for improvement.

Staff protected people's rights by following the Mental Capacity Act 2005 (MCA). The MCA 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Staff were clear about the need to seek consent from people before providing care or support and used a variety of methods to check people were ready and willing to receive the care they offered. The care manager provided examples of how they had supported people to make their own decisions about their care. For example, they described how they supported one person by engaging with them on a one to one basis in a quiet environment, as the person became confused when other people were around. A care worker told us they helped people make decisions by "breaking [the options] down, giving them more time and keeping things simple."

Most people's meals were prepared or provided by family members. However, where care staff were responsible for preparing meals, they encouraged people to maintain a healthy, balanced diet based on their individual needs and preferences. A family member told us, "[My relative] will say she's eaten when she hasn't always. The carers always make sure they leave some food out. They don't assume she's eaten; they know her well." Staff were clear about the support people needed to ensure their nutritional needs were met. For example, they told us one person sometimes declined the lunchtime meal, so a plan was in place for a sandwich to be made for them to have later in the day. They also encouraged people to drink well and made sure people had drinks to hand when they left them. Staff recorded what people had been offered to eat and drink, but not the quantities they had consumed. We discussed this with the care manager, who told us they were in the process of introducing new food and fluid charts that would enable staff to record how

much the person had eaten.

Staff who regularly supported people knew them well and monitored their health on a daily basis. If they noted a change they would discuss this with the person and their family member, if appropriate. With the person's consent, they then sought appropriate professional advice and support, for example from doctors and specialist nurses. Care records showed occupational therapists and physiotherapists had also been contacted when required.

Good

Is the service caring?

Our findings

People's needs were met by staff who worked in a caring and compassionate way. People and relatives told us their regular staff were caring, kind and considerate. One person said, "[My care worker] is ever so nice; she's ever so caring. She takes her time and does everything just right. She only lives up the road and said I could call her if I'm taken ill in the night." Another person told us, "The regular ones are always kind, caring and respectful." A family member said of the care staff, "Most who come are kind, caring and respectful. They talk to [my relative] directly, even though he can't talk back to them. They involve him this way in his care." Another family member described staff as "extremely caring and pleasant".

We observed positive interactions between care staff, people and family members when we visited people in their homes. There was laughter, banter and a good atmosphere between them and people appeared completely at ease in their company.

People felt their regular care workers knew them well and spoke positively about the relationships they had built with care staff, which they valued and appreciated. For example, one person said, "They are like family; I wouldn't change them for the world. My [relative] makes cakes and we have that with a cuppa when they have finished my care." Another person told us, "When [my regular care workers] have helped me get washed and dressed, they don't just rush away; they will stay and have a chat and give me a bit of company." A family member told us, "I am more than happy with [my relative's] care. She has had the same carer for a long time. They have got to know each other well; there is a great rapport between the two of them. She has my phone number and will call if she has any concerns." Another family member said, "[The regular care workers] are part of the family now. I'm blessed to have them. My family even ask about them now, when they ring."

A care coordinator told us, "The carers are really caring. They'll pop round to check people in their own time if they've been unwell. They talk about their people warmly and if something hasn't been done [by a colleague] while they're off, they show concern and flag it up." A care worker told us, "I have a good rapport with [the people I support]. I ask about their families and we talk about our weekends. If you get to know them you can pick up when their having a bad day and know what to talk about to help them out of it."

Care plans included information to help staff build positive relationships with people. For example, they contained details of the person's background, their likes, dislikes and preferences. They also included advice to care staff about how to respect people's privacy while supporting them. We viewed a selection of thank-you cards the service had received. One said, "Just wanted to say a big thank you for all your support and for looking after [my relative]. I have such fond memories of seeing her smile when you arrived to look after her."

People said their privacy and dignity were protected and respected at all times. Staff were sensitive to the fact that they were working in people's homes and took care to be as discreet and unobtrusive as possible. For example, one care worker took their shoes off when they arrived, which showed respect for the person's home. People were able to choose the gender of the staff member who assisted them and could request a

change of staff if they did not feel comfortable with a particular staff member. A person told us they had requested a male care worker and this had been provided and the care manager provided an example of a care worker who had stopped supporting one person because the relationship had broken down.

Staff described the practical steps they took when supporting people with personal care. One staff member said, "I keep doors and curtains shut. If any visitors are there, I ask them to stay out of sight and make sure [the person] is wrapped up when we go back to the bedroom from the bathroom." Another told us, "I explain what I'm doing, try not to show any awkwardness and reassure them that it's all normal." A family member confirmed this, when they told us staff took steps to "minimise the embarrassment" and put their relative "at their ease". Another person told us their care worker "takes care to keep me covered up when I have a bed bath".

People and relevant family members were involved in planning and agreeing the care and support that staff delivered. This started with an initial assessment of the person's needs and was developed over time as people's needs became clearer or changed. Records confirmed that people were also involved in reviews of their care and in discussing any changes they wished to make to the way their care and support was provided.

Good

Is the service responsive?

Our findings

People's regular care workers provided personalised care and support that met people's individual needs. When we spoke with staff, they demonstrated a good awareness of people's individual support needs and how each person preferred to receive care and support. One staff member told us, "Every client is different. They are individuals and have their own needs." In addition, staff knew how to work closely with family members to provide all the necessary care and support for the benefit of the person. They recognised that some people's mobility or cognitive ability varied from day to day and were able to assess and accommodate the level of support the person needed from visit to visit.

Assessments of people's care needs were completed by the care manager, who then developed a suitable plan of care. One person told us, "I had Maycare come to see me before I was taken into hospital for a routine procedure. They came to plan the care I might need when I came home, to get something set up ready; it meant I could be confident it was all sorted, so that I could come home quickly." The care plans we viewed provided enough information to enable staff to provide appropriate personal care in a consistent and individualised way. For example, one person's care plan said they liked the milk for their cereal put into a milk jug before being poured over their cereal; when we visited the person, they confirmed that staff did this for them. Another person had an injury to their left shoulder, so needed their left arm put into clothing first; when we spoke with staff, they were aware of this and confirmed that was how they supported the person to dress.

The care plans included clear directions to staff about the tasks they were required to complete and the way people wished to be supported, such as with medicines and their moving and re-positioning needs. They also contained information about people's health conditions, their life history, preferences and any environmental risks in their home. One person used a catheter. A catheter is a device used to drain a person's bladder through a flexible tube linked to an external bag. There were specific instructions within the care plan to help ensure this was managed appropriately; staff and family members confirmed these were always followed. Care plans had been reviewed every six months, or when the person's needs changed. Those we viewed were up to date and reflected people's current needs.

Staff responded promptly when the needs of people they supported regularly changed. A family member told us staff had identified a change in their relative's toes. They said, "[The care staff] spotted it and recommended we called a doctor; it was an infection. They are very alert to those things." Another family member said, "The regular carer knows [my relative] well; she can pick up on her bad days and then adjusts how she is going to help her." Another person needed an extra visit in the evening after being discharged from hospital and this had been arranged. A thank you card we viewed from a relative said of the staff, 'Their skill in noticing additional medical problems was particularly appreciated'.

People were encouraged to be as independent as possible within their abilities. Care plans included advice as to how staff could achieve this. For example, they specified tasks the person could perform for themselves and the degree of help they required with other daily tasks, such as washing and dressing. One person had broken their hip and required the use of equipment to support them to move. Staff told us how they had

worked with the person to help them regain their confidence and mobility. This had been effective, meaning the equipment was no longer needed to support the person and the number of care workers had been reduced from two to one.

People knew how to complain about the service and there was a suitable complaints procedure in place; this was included in a 'Service user guide' given to people using the service. Complaints that had had a significant impact on people had been recorded and investigated thoroughly. For example, incidents which resulted in harm to people had been documented and action had been taken to reduce the likelihood of a recurrence. In one case, the registered manager told us they had agreed to pay compensation for food that had spoiled when a staff member had not spotted that a person's fridge and freezer had been turned off. Other complaints relating to the behaviour of staff and medicine administration errors had also been resolved appropriately.

The provider sent questionnaire surveys to people and their relatives to assess and monitor people's satisfaction with the service. Responses were then collated and analysed to identify improvements that could be made. Two responses identified concerns relating to the handling of complaints. In response, the care manager had developed an action plan to address this (and other) issues; we were sent a copy of the action plan following the inspection. It included details of the staff member responsible for each piece of work, a timescale for completion and monitoring arrangements.

Reviews of people's care were also used as an opportunity to seek the views of the person and their relatives about the quality of the care delivered. Where changes were requested, these were accommodated. For example, a family member had asked that any new care workers worked alongside experienced care staff before supporting their relative, due to the complexity of their needs. When we spoke with the family member, they told us suitable arrangements for this had been put in place and were working well.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a duty of candour policy in place to help ensure staff acted in an open and transparent way when people came to harm. The care manager told us they had responded to safety incidents by being open and honest with people or their relatives and providing information verbally. However, they had not provided written information about such incidents, as required by the regulations. We brought this to the attention of the registered manager, who told us they would develop an appropriate policy without delay.

In other ways, the service was open and candid. The previous inspection rating was displayed in the office and on the provider's website. The managers notified CQC of all significant events and staff told us they were made welcome when they visited the office. The registered manager and the care manager were responsive to issues raised during the inspection and expressed a commitment to improving and developing the service for the benefit of the people using it.

The service had a set of policies and procedures, but those we viewed were not update or reflective of the type of service being provided. For example, the infection control policy referred to out of date guidance issued by the Health & Safety Executive. Other policies referred to the old care standards and related to an NHS setting; they did not reference the fundamental standards of quality and safety currently in use for adult social care providers. Similarly, the provider's Statement of Purpose (SoP) related to the provision of staff to other health and social care providers, rather than the delivery of personal care by Maycare staff. We discussed these issues with the registered manager, who agreed to update and refresh the service's SoP, its policies and its procedures.

There was a quality assurance process in place, but this was not always effective in monitoring and improving the quality and safety of the service. This included a 'Logbook audit' to assess the quality of record keeping by care staff. Following the latest audit in July 2016, an action plan was developed to address concerns identified. This included a new procedure to monitor the performance of new staff and a discussion about the importance of good record keeping at the next staff meeting. Records confirmed that these action had been completed. However, the audit also identified 'a large number of clipped visits'. A clipped visit is when staff do not stay with the person for the agreed length of time. We found no specific actions had been identified to address this issue and people told us this was an on-going concern. The quality assurance process had also not identified that staff were working before pre-employment checks had been completed and that visits to people were not always made at the required time or by staff who could meet the person's needs effectively. We discussed the issues with the registered manager, who agreed they were an area for improvement.

To check that staff were working to the required standards, the care manager conducted 'spot checks' of care workers. These covered all aspects of their work, including punctuality, safeguarding, moving and positioning practices, medicine administration, dignity and respect. Where the checks indicated staff needed additional advice or support, this was provided. In addition, the care manager often worked alongside care workers, when the support of two staff was needed, and this helped them assess the

performance of care staff. However, most staff told us they only received one or two spot checks each year, rather than the four specified by the provider's policy. We discussed this with the registered manager who said they were planning to develop a "definable policy" to help ensure spot checks occurred more often in the future.

Most people told us they were satisfied with the care they were currently receiving from their regular care staff and were able to contact office staff for support. Comments included: "I have an out of hours telephone number and one for the office if I need it"; "The people in the office are very nice and deal with any queries"; and "We can always contact the office and they try and sort out any concerns".; and "When I've had to call, as the carer is late, they will deal with it straight away; but the manager never seems to be available and never calls back".

People benefitted from staff who were happy and motivated in their work. Feedback from staff was sought on a regular basis, including through staff meetings, and they were encouraged to make suggestions about improvements that would benefit people. Care staff told us the care manager and the registered manager were "lovely", "supportive" and "approachable". Other comments from staff included: "[The managers] value and appreciate us. They acknowledge it in the monthly newsletters, or with boxes of chocolates, and they are always saying 'thank you'"; "I love working here. I feel appreciated by [the registered manager] in particular"; "[The care manager] is lovely; if she can help, she will"; "[The registered manager] is very professional. She wants things done properly"; and "I would recommend it as a place to work."

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that the care and support provided was appropriate and met people's needs at all times. Regulation 9(1).

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to operate safe recruitment procedures, and ensure that all staff were of good character prior to being employed. Regulation 19(1), (2) & (3).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient staff were deployed to meet people's needs at all times. Regulation 18(1).