Hilton Nursing Partners Limited

Beech Tree Total Care

Inspection report

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

Summary of findings

Overall summary

The inspection took place on 28 October 2016 and was announced. We gave the service 48 hours notice of our inspection because we needed to make sure there was someone available at the provider's offices. This was our first inspection of this service.

Beech Tree Total Care provides personal care and support to people in their own homes. There were 96 people using the service at the time of our inspection.

The service has a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. People did not always know who the registered manager was but found that there was always a member of staff they could speak with at the office if they needed to.

The provider's quality assurance systems did not always capture and address all areas that required improvement within the service. The people who used the service and their relatives were able to contribute to the development of the service by way of satisfaction surveys. Six monthly staff meetings were also held as a way of involving staff in the development of the service.

Staff were trained in safeguarding people and they knew how to keep people safe. People had care plans in place but they were inconsistent and there was one care plan for 2 people which was not reflective of person-centred care. People had risk assessments that gave guidance to staff on managing risks that people were exposed to. There were enough staff to provide care to people who used the service and we found that there was only one missed care visit in an eight weeks period. However, the deployment of staff meant that the travel time allocated to staff from one care visit to the next was not always adequate. Consequently people experienced rushed or late care delivery and calls that were shorter than they should have been.

Staff were trained and understood their responsibilities under the Mental Capacity Act 2005. They were respectful of people, their dignity and privacy, and they made sure they sought people's consent before they provided care. Where necessary, staff supported people with their nutritional needs and to have access to healthcare services. Staff were supported in their roles by way of supervision and appraisals of their performance.

People and their relatives found staff to be kind, caring and of good humour. Positive relationships had been developed by staff with the people who used the service and their relatives. Staff were knowledgeable about the people they cared for. There was an effective system in place for managing complaints.

During this inspection we identified that there were breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to the safe care and treatment of people and person-centred

care. You can see what action we told the provider to take 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.

The provider did not allocated sufficient travelling time between visits.

Improvements were required in the way people's medicines were managed.

People had individualised risk assessments to manage risks they were exposed to but risk management plans needed to be more robust in providing guidance to staff.

Staffs' recruitment records were up to date. However one did not hold robust references from previous employers.

There were enough staff to provide care to people who used the service.

Staff were trained in safeguarding people and they knew how to keep people safe.

Is the service effective?

Good

The service was effective.

Staff were knowledgeable about people's care needs.

Staff understood their responsibility to seek people's consent before providing any care.

There were plans in place to improve the service's practices around the Mental Capacity Act 2005 and staff understood the requirements.

Staff received supervision and appraisals of their performance as way of supporting them in their roles.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were kind, caring and of good humour.

Positive relationships had been developed by staff with the people who used the service and their relatives.

Staff were knowledgeable about the people they cared for.

Staff were respectful of people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was responsive.

People had care plans in place but they were inconsistent and there was one care plan for 2 people.

People's care needs were identified before they started using the service.

Staff had clear understanding of people's needs and supported them in line with their care plans.

There was an effective system in place for managing complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider's quality assurance systems were not always effective in identifying areas of improvement.

There was a registered manager in post.

The provider sought the opinion of people who used the service and their relatives by way of satisfaction surveys.

Beech Tree Total Care

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 on 28 October 2016 and was announced. The provider was given 48 hours' notice because the service is a domiciliary care agency and we needed to be sure that staff would be available on the day of the inspection. This was our first inspection of this service.

This inspection was carried out 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 had experience of caring for older people who use services such as this one.

Before the inspection, we reviewed the completed Provider Information Return (PIR) which the provider had sent to us. The PIR is a form that asks the provider to give some key information about the service such as, what the service does well and improvements they plan to make. We also reviewed information we held about the service including notifications. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with six people who used the service. We also spoke with four relatives of people who used the service, four care staff, one care coordinator, the trainer, the office manager, the provider's chief executive officer (CEO) and the registered manager. We reviewed the care records, risk assessments and medicines administration records of seven people who used the service, and we looked at the recruitment and training records for four members of staff. We also reviewed information on how the quality of the service, including the handling of complaints, was monitored and managed.

Requires Improvement

Is the service safe?

Our findings

Some of the people who used the service were supported by staff to manage and take their medicines. For some people, staff prompted or reminded them to take their medicines and others were supported fully with the administration of their medicines. Improvements were required in the management process of people's medicines. Information contained in some people's care records was not consistent with the support staff provided. For example, one person's care records stated that their spouse was responsible for all aspects of their care around medicines. However, in another part of the record it was noted that staff were to administer the person's prescribed medicines following the pharmacy produced medicines administration record (MAR). This inconsistency placed people at risk of receiving care that was not appropriate in relation to their medicines.

We found that people's MARs were regularly returned to the provider's offices for auditing purposes. We reviewed seven people's MARs and noted that mostly they had been completed correctly. However, one person's had been removed from their home by a healthcare professional for a week. During that time, staff continued administering the person's medicines without their MAR. Although staff were aware of the person's routine around the use of their medicines, this practice heightened the risk of harm to the person by way of medicines error.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us that staff usually arrived late to care visits because travel times in between care visits were not provided. One person told us, "The timing is not good. They [Staff] often arrive quite late and then arrive early for the next call so there is a small gap in between." Another person said, "It does vary [time of arrival] but they are not allowed travelling time so there is no wonder." One relative told us, "They are mostly on time but can get held up with traffic. They don't get travel time so [that causes late calls]." Another relative said, "They can arrive early in the morning actually and it [the time of arrival] varies but it suits us anyway. They don't inform us [if they are running late]."

Staff we spoke with confirmed travel time in between care visits were not provided and told us that this caused people and their relatives unnecessary anxieties. One member of staff said, "There is no travel time, you are supposed to fly [in between care visits]. I am glad I haven't had a speeding [fine]. The poor last client [last person to be cared for at the end of the day], [their] visit is well late, sometimes they are half an hour late other times they are up to an hour late. The office staff don't always tell them [people] when staff are running late and they get upset not knowing what is going on and worry about what has happened to the staff. This is a big issue." We asked this member of staff if the provider and the registered manager were aware of the lack of travel time and the impact it was having on people who used the service and staff. They answered, "I'm sure they are, everybody is [aware]." The issue about the lack of travel time was also confirmed by another member of staff who told us, "Although most calls [care visits] are in the same area, there is just no travel time which makes it all very difficult."

We reviewed the staff roster with the planned care visits and people's home addresses which confirmed the lack of travel times, and late care visits. We raised this with the registered manager, they told us the issue could be easily resolved and they agreed to have it addressed with immediate effect.

People we spoke with and their relatives told us there were enough staff to safely meet people's needs. One person said, "Yes they always stay and do everything for me." Another person told us, "They are excellent, they always ask if there is anything else I need." A relative said, "They are very flexible. They have often stayed longer if we need them to." A review of the provider's care visit logs from August 2016 to the date of our inspection showed that all care visits had been attended meaning there were no missed care visits. However, there was a number of care visits that were shorter than planned. We found a care visit that was planned to run for half an hour but only lasted nine minutes. There were care coordinators who monitored the care staffs' visits but there were no records that showed the actions the provider took to address short care visits.

The deployment of staff led to people experiencing late, shortened and rushed calls and this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a recruitment policy in place which gave guidance on the safe recruitment of staff. They carried out pre-employment checks before staff started working at the service as a way of safeguarding people. These checks included checking employee's identity and their employment history. The provider also obtained references from previous employers and completed Disclosure and Barring Service (DBS) checks. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed. We looked at the recruitment records for four members of staff. We found that one record did not hold robust references from the person's previous employers. This was because the reference were not accompanied by company logos or stamps to evidence they were in fact provided by the appropriate organisation. We brought this to the office manager's attention to be addressed accordingly.

There were systems in place to safeguard people from avoidable harm. People and their relatives told us that the service was safe. One person said, "They are all excellent so I always feel safe yes. I would tell my family if not." Another person told us, "I feel very safe with them [staff]. It's important they know what they are doing, I would speak to the office, if [I felt unsafe]." A relative told us, "Oh yes [Relative] is safe in their hands. I am always here so I would know if [they were] not safe."

The provider had an up to date safeguarding policy that gave guidance to the staff on how to keep people safe. Staff were aware of this policy and had received training on safeguarding people. They demonstrated a good understanding of what constituted abuse, and what actions they would take if they suspected or witnessed a case of abuse. A member of staff told us, "I have received face to face safeguarding training. We make sure clients are safe, their needs met, not neglected and report any concerns." This member of staff explained the types of abuse or risks that could affect the people who used the service and gave us an example of a concern they reported. They said, "I visited a client who had put a [plastic] pack of ham in the oven. I reported it to the office, they log it and report it to the family, social services or the care manager depending on the arrangement." The office manager told us that an agreement had been reached by those involved in the person's care to disengage their oven rendering it dysfunctional in order to safeguard the person. A review of the provider's safeguarding records against information we received prior to our inspection showed that safeguarding concerns were reported to the relevant authorities as appropriate. The provider also had a whistleblowing policy in place. This gave staff guidance or ways they could report misconduct or concerns within their workplace. Again, staff were aware of this policy and told us they would use it if required.

People who used the service had personalised risk assessments in place. These identified the risks relating to their care, health or wellbeing, and detailed the measures in place to safeguard them from potential harm. The care staff were aware of the identified risks to people and the measures that were in place to manage risks. A member of staff told us, "One of the coordinators visits all the new clients and carry out risk assessments involving the clients and their families." We looked at seven people's risk assessments and although they were reviewed regularly to ensure the level of risk was still appropriate, there were instances were risk management plans could be made more robust. For example, one person's records stated 'they could become agitated with new faces and at times could lash out with their arms and legs when staff provide personal care'. The risk management plan did not provide staff with adequate guidance on managing such situations if they occurred. We raised this with the registered manager and the office manager who told us that the person's care records would be reviewed and more robust assessments developed.

Good

Is the service effective?

Our findings

People and their relatives told us that the care people received was effective because staff were trained, and skilled in delivering care that was appropriate. One person said, "They are all very good, very well trained." Another person told us, "They have excellent skills all of them. They are very well trained." One relative said, "I am very satisfied with their level of competency." Another relative added, "They are well trained, they give a good all round service."

The staff we spoke with confirmed they were provided with the training they needed to carry out the roles. One member of staff told us, "They are good at keeping an eye on training. We get a lot of training which is all face to face [classroom based] and we have the annual refreshers." We also spoke with the service's trainer and they told us, "I train all the staff on the mandatory subjects and also source external training for them because we cater for clients with specialist needs." Staff training covered areas such as safeguarding, medicines, moving and handling, food hygiene and dementia awareness. We found that the trainer had developed a training matrix used to monitor staffs' training and when they were due to be refreshed. A reviewed of this training matrix confirmed staff training was up to date.

The staff recruitment records we looked at confirmed staff had received an induction at the start of their employment. A member of staff we spoke with told us, "We have all had an induction, you do your shadowing [work alongside more experienced staff] until you become confident before you work on your own. The amount of time you spend shadowing depends on your level of experience. If you've never worked in care before it can be for a couple of weeks. It really is down to the person but it's generally until they feel ready." Another member of staff told us that their induction was useful as it made them understand their role and the needs of the people who used the service.

Staff were supported in carrying out their roles by way of regular supervision and appraisal of their performance. A member of staff we spoke with told us, "We have supervisions every three months and appraisals every year." The provider had a system in place for monitoring the frequency of supervision meetings. A review of this confirmed supervision took place and that appraisals were carried out annually.

Some of people who used the service were able to consent to their care and support. However, some people's health needs meant that they did not have capacity to make decisions about some aspects of their care. Where required, their relatives and social care professionals were involved in ensuring that any decisions to provide support were in the person's best interest, in line with the requirements of the Mental Capacity Act 2015 (MCA). The 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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Applications must be made to the Court of Protection.

There had been no applications made to the Court of Protection in the records that we reviewed.

Staff were trained and they understood their responsibilities under the MCA. A member of staff we spoke with told us, "The MCA is an enablement that when people get to a certain age [adulthood] they have the right to make their own decisions and you respect their decisions. You can advise them if you feel their decision is not wise but you can't stop them." Another member of staff said "If we have a client who is non-verbal, we use hand gestures to show what we are going to do and ask permission. Sometimes, we will write things down. I presume senior staff do capacity assessments, I have had training in MCA." A review of people's care records showed that improvements were required in the management of people's care where they lacked mental capacity to make certain decisions. For example, we saw instances where information contained in people's care records indicated that they did not have capacity to consent to their care but capacity assessments were not carried out. Instead their relatives gave consent without the MCA process being fully engaged. We raised this with the registered manager and they showed us evidence that plans were in place to improve the service's practice around MCA following a CQC inspection of another service they managed. They said that the improvements were being made at the time of people's care reviews.

People and their relatives told us that staff asked people's permission before they provided care. One person said, "Yes, they ask me if it's okay before they do anything." Another person told us, "Yes they talk to me all the time." One relative said, "I can hear them talking and saying what they are doing." We were satisfied that staff had clear understanding of their responsibility to seek people's consent before providing care or support. In a conversation with a member of staff about this subject they told us, "We always ask their [people's] permission. For example you say [Name removed] is it okay that I do this or that, and you always tell them what it is you are doing, because it is their body and they can always say no. It's their choice."

Some of the people who used the service were supported by staff to have regular food and drinks. For the majority of people, this meant that staff warmed and served ready-made meals to them. The people we spoke with and their relatives made positive comment around the nutritional support staff provided to people. Comments made included, "Yes they leave a lunch for me. There's no problems there," and "They do help [Relative] to eat [their] meals which gives me a break too."

People or their relatives managed their own access to health services such as GPs, dentists, or to attend hospital appointments. There was information in people's care records about their healthcare needs and the healthcare professionals or services involved in people's care. This provided guidance to staff on ensuring people had the right support and treatment if they became unwell.

Good

Is the service caring?

Our findings

Positive relationships had been developed with people who used the service. They and their relatives talked of staff who were kind, caring and of good humour. One person said, "They are excellent all of them without exception and they have good sense of humour!" Another person told us, "They are all very good, lovely [staff]." One relative said, "They are all very kind, caring [staff]." Another relative told us, "They are all very nice. I am satisfied with them." One other relative added, "I am very happy with them. They are very friendly but have appropriate behaviour." With such feedback we were satisfied that staff interacted with people in a positive manner.

Staff demonstrated genuine compassion for the people who used the service. One member of staff told us, "The service is very good, I have worked in others but here it is like a community. We are professional but we try and become a friend and resolve any problems they [People] may have." Another member of staff said, "I will recommend the service. We have minor issues but the carers are good and we offer a good service." Such positive comments from staff reinforced the view that staff and people who used the service had developed positive relationships.

People told us they were happy with the care they received and that they felt listened to. One person said, "They know me very well. I get my views across and they do listen to me. They are always very respectful." We found staff to be knowledgeable about the people they cared for. They spoke with confidence about the care they provided to people and the outcome people wanted from their care. One member of staff was able to tell us about the needs of the people they supported, which was in line with what was recorded in their care records. These contained information about people's care needs, preferences and choices.

People who used the service and their relatives told us that staff were respectful of people's dignity and privacy. One person said, "I feel very comfortable with them. They just get on with the job and make me feel relaxed." Another person told us, "Yes they treat me with respect." One relative said, "They are very respectful, but still friendly. And they always respect [relative's] privacy." One other relative added, "I would say they know [relative] very well and they respect his dignity and chat with him all the time." Staff recognised the need to be respectful of people, calling them by their preferred names, conducting personal care in private and only discussing their care needs on a need to know basis. One member of staff told us, "We never assume and we always ask permission before doing anything and respect their choices." This was confirmed by one person who told us, "They are respectful they ask me if it's okay before they do anything."

The 'beech tree home care support services' leaflet was available to people and their relatives. This contained information about the services offered to people and the locations and contact details of the provider. Some of relatives or social workers acted as people's advocates, where they were unable to do this by themselves. Others had support from independent advocacy services to ensure they understood the information given to them and that they received the care they needed.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed before they started using the service. One person we spoke with confirmed this and said, "I say what care I need." This was also confirmed by staff. One member of staff told us, "One of the co-ordinators visits clients to do an assessment before the care package starts. They make a note of what support is required, do a risk assessment and write down everything like the client's next of kin, their GP and medicines before carers go in. They involved the client or their family in the assessment process." A review of people's records showed that needs assessments had been completed from which people's care plans had been developed.

People's care plans took account of their needs, preference and wishes, and gave clear guidance to staff on meeting their individual needs. Staff demonstrated clear knowledge of people's care needs. Care plans were located both within the provider's offices and at people's homes. People told us that they were involved in planning and reviewing their care. One person said, "Yes I have a care plan." Another person told us, "I have a care plan, yes, and I was involved in it." A relative we spoke with told us, "We had a review only yesterday. We were both involved in it." When we looked at people's care plans we found that there were some inconsistencies within the plans. For example, sections of one person's contained conflicting information around their use of medicines. For another person, the times of their care visits were not reflective of what was in their care plan. We also found that a couple who lived together and had similar needs were sharing one care plan. This was not reflective of person-centred care, although the care itself was said to be personalised by people when we spoke with them.

The practice of two people sharing one care plan was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of people's care plans and they had a clear understanding of how people wanted to be supported. People's care plans included information about their health and support needs, which enabled staff to provide a personalised service. Although some of the people we spoke with told us that they had consistency of the staff that visited them, there were people who told us that they didn't always have the same staff. However, everyone agreed that staff knew them well.

The provider had a complaints policy in place. People and relatives told us that they had no difficulty in raising concerns. A person we spoke with said, "No I have never had to complain. I would ring the office if I did." Another person told us, "I would ring the office if I had a complaint." One relative said, "I haven't had a copy of their complaints procedure but would phone them if need be." Another relative told us, "No I have never had any complaints." A member of staff added, "If someone wanted to complain I would make sure they had our complaints form or call social services if it was something else." We reviewed the records of complaints that had been made and found that they had been investigated and resolved appropriately.

Requires Improvement

Is the service well-led?

Our findings

The provider had a quality assurance system in place. Quality audits were carried out by the registered manager and the office manager. Quality audits included spot checks to review the quality of the service provided, audits of care records, Medicine Administration Records (MAR) and daily visit records to ensure that all relevant documentation had been completed and kept up to date. Action plans were developed when required to address any improvements that were needed following these audits. However, the shortfalls in the provider's arrangements of care visits, and mostly the lack of adequate travel time for staff in between visits had resulted in people reportedly feeling anxious. This was because they were not sure what time the care staff would arrive and also had experienced care that was rushed. Staff we spoke with told us that the management team were aware of the issue but action was yet to be taken to address this. We raised this with the registered manager and they told us that immediate action was going to be taken to address the issue.

The service had a registered manager in post. They were supported by the office manager and the chief executive officer (CEO) in providing leadership of the service. The registered manager also managed another service which meant that the office manager was in charge of the day to day operation of the service. People we spoke with and their relatives did not know who the registered manager was. This was not a concern to them as there was always someone they could talk to at the office if need be. One person said, "I'm not sure who the manager is but I would know who to talk to." Another person told us, "The management is always changing but I always get through to somebody." A relative said, "I don't know who the manager is at the moment but would phone them anyway."

Staff we spoke with commented positively about the leadership and management of the service. They told us that the management team were visible, approachable and supportive. A member of staff we spoke with told us, "Once I went to a client's house and found that [they] had died. They came out as soon as I called. They gave me the day off and offered me counselling. They were very supportive." The CEO told us about the governance of the service and their ethos. They said, "We have field resources and a clinical governance team that supports this and other services [within the organisation]. Good practice and challenges are shared and dealt with by them and within the team. I visit the service monthly and cover for [registered manager] when [they] are on leave. I don't only visit when something goes wrong, I come in to celebrate compliments and also when things go right. We are a team. The staff have my contact details and can contact me at any time. Our ethos is mutual respect for one and other, no one is more important than the other and we respect each other."

We found that the office manager worked with the shift co-ordinators in the provider's offices and met with the care staff mostly on a daily basis. Care staff shared their experiences or handed over any information as was required. The management team were aware of the day to day culture and experiences of the staff team. We observed staff communicating with the management team, including the CEO, in an open and friendly way. We were satisfied that the leadership was open, visible and approachable.

Staff we spoke with told us that team meetings used to take place frequently and gave them the chance to

be involved in the development of the service. However, they had become infrequent. One member of staff said, "We used to have team meetings a lot but not as many now. It's a shame because we don't know other carers. They are just names in a book." We raised this with the registered manager and the office manager after our inspection. The office manager told us that team meeting were held six monthly but if issues needed to be discussed before then a meeting would be arranged.

People and their relatives were also able to contribute to the development of the service by way of satisfaction surveys, which were carried out yearly. One person told us, "I have received a survey and it is a good company." Another person said, "Yes I receive surveys and they come out every six months or so." The results of the surveys were used to identify areas of improvement to be made. The latest satisfaction survey was carried out in June 2016. We reviewed the outcome of this survey and found responses to be mainly positive, with comments such as, "I am very pleased with Beech Tree and the staff that come to see my [Relative], they are kind and very cheerful at all times", and "Very reliable daily service", made. There were also comments that suggested areas of improvement such as, "Be on time and continuity with carers as much as possible" and "Let me know when times are altered."

The provider also had a system for handling compliments that were made about the service, the staff and the care that was provided to people. We reviewed records of compliments and found one that read, "Thank you very much for the excellent care Beech Tree gave me at my time of need. Your carers are exceptionally good. They must be very carefully selected. I am very pleased with the service you offered and I will be very happy to recommend you."

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 Two people were sharing one care plan.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always being managed for accounted for correctly.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The deployment of staff led to people experiencing late, shortened and rushed calls.