Bespoke Care at Home Ltd

Bespoke Care At Home

Inspection report

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Date of inspection visit:
19 February 2019

Date of publication:
20 March 2019

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service:
This is the single location within the provider's current registration. The office is in the central business district of Burnham. Areas covered included Maidenhead, Slough, Windsor, Burnham, Marlow, Cookham and Dedworth. At the time of our inspection, 65 people used the service and there were 53 staff.

People's experience of using this service:
Risks to people's well-being were assessed, recorded and updated when people's needs changed. Training records showed that people were supported by skilled staff that had ongoing training relevant to their roles. The service was a family run company which contributed to creating a personal touch and a strong, visible person-centred approach. The provider had effective systems to manage complaints. Staff said the provider successfully maintained an open and transparent culture which contributed to staff work satisfaction and in turn the staff delivering good care for people

Rating at last inspection:
This was our first inspection of the service since the registration changed in January 2018.

Why we inspected:
This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received. We inspect newly-registered services within 12 months of registration.

Follow up:
We will continue to monitor the service to ensure that people receive safe, compassionate, high quality care. Further inspections will be planned for future dates.

For more details, please see the full report which is on our website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our Well-led findings below.

Bespoke Care At Home

Detailed findings

Background to this inspection

The inspection:
We carried out our inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. Our inspection checked whether the provider was 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.

Inspection team:
Our inspection was completed by two inspectors, an assistant 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. Our expert by experience had knowledge about the support of older adults within care at home settings.

Service and service type:
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 adults, people with sensory impairments or physical disabilities and people with dementia. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
Our inspection was announced. 48 hours' notice was given so we could be sure the registered manager was available as they were often out of the office providing care.

What we did:
Our inspection was informed by evidence we already held about the service. We also checked for feedback we received from members of the public, local authorities and clinical commissioning groups (CCGs). We checked records held by Companies House and the Information Commissioner's Office. We asked the service to complete a Provider Information Return. Providers are required to send us key information about their service, what they do well, and improvements they plan to make.

We spoke with five people who used the service and five relatives. We spoke with the nominated individual and registered manager. We spoke with two care workers and various office staff. We reviewed five people's care records, seven staff personnel files, audits and other records related to the operation of the service.

We requested additional evidence to be sent to us after our inspection. This was received and the information was used as part of our inspection.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Good: People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse
• People received safe care. They said, "Yes, they aren't any threat. They arrive, they are pleasant and polite and get on with what they have to do" and "Absolutely. They do what I ask them to do and I have no issues at all with them."
• Care workers were aware of what constituted abuse or neglect. They knew to report any allegations of abuse to the field care supervisor or the registered manager.
• Any allegations were reported to the relevant local authority. Other authorities, such as police, were alerted when needed.
• Safeguarding incidents were logged on file and associated investigation records were saved for each matter.
• We received notifications of any allegations of abuse or neglect, in line with the relevant regulation.
• Investigations were completed to ensure that facts were established and actions taken to ensure the safety of people affected was maintained.
• The registered manager had completed advanced level training in safeguarding. The registered manager had established the role of a safeguarding lead for the service. Care workers completed safeguarding training during their induction and annually. Scenarios were used to assist learning.
• The nominated individual explained an instance where a care worker's vigilance in a case protected a person's financial status.
• A robust whistleblowing process was in place. This was used and had ensured that relevant information was reported by staff

Assessing risk, safety monitoring and management
• The registered manager explained that new care packages were not commenced without staff having the necessary knowledge and skills to deal with a person's needs.
• A full assessment was completed with a person and their relatives to determine the care risks. These included medicines, equipment, health, home environment and fire safety.
• Assessments took place in hospitals, care homes and people's own residences. Information from local authorities was used to assist with the assessment of people's risks. Existing care documentation from other organisations was also used to inform risk assessments.
• A scale of risk was used which ranged from no risk to extreme risks.
• Actions were documented to mitigate risks. For example, where a risk for moving and handling was identified, all necessary equipment was obtained and checked before use.
• One person had a behaviour which meant they challenged staff. The service ordered and used arm guards to protect the person and staff.
• Risk assessments were reviewed at regular intervals and more frequently when changes in a person's health had occurred.

Staffing and recruitment
• Staffing was based on the number of hours contracted by the commissioner. For people funding their own care, the field care supervisor in conjunction with the person and their family determined a safe number of support hours.
• A relative told us care workers were generally on time. They stated, "They are always on time and never miss. The office staff are trained carers too."
• Care workers had identified instances where a person's care was planned for one staff member and found the needs exceeded the staff deployment. They liaised with the commissioner and ensured that two care workers attended.
• An assessment for one person was underway which would mean that three care workers and a live-in staff member were planned for support. The person had behaviours that challenged and therefore the staffing was based solely on the person's needs.
• Depending on circumstances and to ensure safety of people and staff, the service would refuse new packages where there were not enough available slots.
• Late calls were defined as 30 minutes past the planned start of a call. Care workers were responsible for calling the office to advise of late running calls. Late calls were monitored by the management team reviewing care log books.
• On rare occasions where a missed care visit was detected or reported, the management team investigated the matter. They contacted the care worker responsible to find out the reason and organise a care call. A letter of apology was sent.

Using medicines safely:
• People had medicines risk assessments which demonstrated their support needs.
• Care workers were responsible for prompting and administering medicines. For people who self-medicated, care workers checked that the person had taken their medicines.
• Care workers completed medicines via an accredited organisation. There were also two staff at the service who provided medicines training. A competency test was completed to ensure that the care worker was safe at administering medicines.
• Medicines administration records were correctly completed to ensure accurate information about people's medicines was documented.
• Where short term medicines were commenced (for example antibiotics) these were well-managed until the course was completed.

Preventing and controlling infection
• The service had a dedicated lead for health and safety. Part of this role included the oversight of infection prevention and control.
• The lead had completed advanced training in infection prevention and control so that they could provide best practice advice to the service.
• Staff were required to complete training during their induction and annually. This ensured their knowledge about infection prevention was up-to-date.
• Staff had access to personal protective equipment (PPE). This included gloves, gowns, masks and shoe covers. Staff could wash their hands at people's houses and carried alcohol-based hand gel for disinfecting their hands as needed.

Learning lessons when things go wrong:
• Incidents and accidents were reported to the office. This included from people who used the service, relatives, care workers and health or social care professionals.
• In most instances, incidents were telephoned or e-mailed to the office staff. All incidents were logged on a record form and in the electronic daily notes.

• The management team ensured the person's safety as a priority. For example, if a GP or district nurse was required for the matter then this was organised.
• Incident forms contained detailed information and reviews by the management team. Records of actions taken during and after the incident were maintained.
• There were lists of actions for care workers to take to prevent recurrence of similar incidents.
• People were protected from harm that arose from people's emotions. For example, one person who had declared depression was assisted to seek professional assistance and eventually moved into a care home.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Assessments we saw of people's needs were comprehensive and set within the context of their wider health condition. Sensory, mobility and communication impairments were recorded.
• Care and support provided by their family and friends, the person's capacity for decision making and their religious faith was also noted.
• Consideration was also given to people's preferences, for example for a male or female care worker and the foods they like to eat.
• Care plans provided care workers with detailed instructions on how personal care should be given to the individual so that it meets their needs safely and effectively. Care plans promoted people's independence, for example while supporting a person to move around their home.
• People's needs and their care plans were reviewed regularly to ensure the service continued to meet the individual's need and that outcomes were being achieved, for example that a person's mental health remains stable.

Staff support: induction, training, skills and experience
• People said staff were knowledgeable and skilled. They told us, "They wouldn't be doing their job otherwise", "Yes, they are fine. I am very pleased with them. I look forward to them coming" and "Yes, they are really. There are some young [staff] with them, but they are always with an older member of staff."
• Staff received the training they needed to remain up to date with current care best practice. Mandatory training, for example on safeguarding and health and safety, was regularly updated and staff had also completed additional training to enhance and develop their role, for example dementia awareness, train-the-trainer and leadership and supervision.
• The Care Certificate formed the basis of the induction programme for new care workers joining the service. The Care Certificate is a set of standards that sets out the knowledge, skills and behaviours expected for specific job roles in the health and social care sectors that has been nationally agreed.
• Staff received regular supervision which provided them with the opportunity to discuss with their line manager their work plan, priorities and objectives and any personal issues which may arise. They also received an annual appraisal where their performance for the year was evaluated, any areas of high achievement were recognised and plans for future development were made.
• Evaluation of staff competencies, for example on medication administration, were made in the field in people's homes. There were audits and spot checks and these were carried out more frequently to ensure people always received effective care.

Supporting people to eat and drink enough to maintain a balanced diet
• Care plans included instructions to care workers to leave snacks and drinks close at hand, for example, to

ensure the person had enough to eat and drink throughout the day. They also included any food preparation to be completed, for example a sandwich for a person's supper.

Staff working with other agencies to provide consistent, effective, timely care
• We saw examples of the service working with community occupational therapy, for example, to ensure a person had the right mobility aids to keep them safe in their home.

Supporting people to live healthier lives, access healthcare services and support
• We saw one example of care workers being involved in multidisciplinary meetings including a dietician, community psychiatric nurse and social worker, to work out ways of better meeting a person's needs.
• A relative stated, "They liaise with other health professionals. For example, they arrange for a community nurse to come in to help [the person] exercise. We were running out of pads and the carers gave us a number to ring to sort that out. We are aware that dental and opticians are in the community and we will access them as and when.

Ensuring consent to care and treatment in line with law and guidance
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.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority.

We checked whether the service was working within the principles of the MCA.

• There was evidence of mental capacity assessments when needed and the outcomes were recorded. The service worked with next of kin and family members where necessary to ensure care was provided in a way that would be acceptable to the person.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were truly respected and valued as individuals; and empowered as partners in their care in an exceptional service.

Ensuring people are well treated and supported; equality and diversity:
• People's needs were identified, including those related to protected equality characteristic such as age, disability, ethnicity and gender. The service was concerned to respect their choices and preference and gave explanations to the person on those occasions when this was not possible.
• People said staff were kind and compassionate. Feedback included, "Yes, they are very good. I get on well with all of them, "They are always there to help me and if I am upset, they are there to help me", "Yes, they mean well. If the house wants hoovering, they ask me if they can do it as they say it needs doing", and "Yes, they are fine."
• Relatives provided positive feedback about staff. Examples included, "Yes. There are some very nice carers they are good with my husband" and "They have good sense of humour which helps. We have lot of laughs. I just find their whole attitude is positive and caring. I feel they have a relationship with my wife."

Supporting people to express their views and be involved in making decisions about their care
• Satisfaction surveys were sent out to people and relatives twice a year. The registered manager explained this provided the opportunity for feedback that the service could use to "Learn from and improve our service."
• Survey feedback included, "[The care worker] is very helpful and happy to do any of the jobs given."
• The management team analysed the results of the surveys returned. The feedback showed people were very happy with the support they received. For example, 90% of respondents rated the care as "excellent" or "good".
• The management team used the feedback to make changes to the service. For example, staff were provided further training to ensure communication was always effective between people and care workers.
• People said care was explained to them and they were involved. One person told us, "I have got a [care] book. They [staff] fill in each time they call, and they came and told me what they could do for me." Another person told us, "Someone came around and explained it all (the care package). Everything has worked out fine."

Respecting and promoting people's privacy, dignity and independence:
• People and relatives reported the care was dignified and maintained privacy.
• People said they were encouraged by to be as independent as possible. Comments included, "Yes, they do [encourage my independence]. I do the washing, shower and help with the cooking", "If I want to do part of my shower, they [staff] will let me" and "Yes, they do. If I want anything doing, I will do it or get some else to do it."
• A person explained how they care they received prevented early admission to residential adult social care.

They said, "It helps me to be independent. If they (the service) weren't around and my husband wasn't, I would have to go in a home."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that services met people's needs

Good: People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Staff showed us they knew people's likes and dislikes. They used this knowledge to care for people in the way they wanted. For example, care plans had very clear details around how a person preferred to be supported with personal care and tasks necessary to obtain the desire outcome and actions carried out were recorded by staff and available to managers.
• There were also regular spot checks were carers were observed in doing their work in people's homes.
• We saw from care plans that people were empowered to make choices and have as much control and independence as possible, including designing outcomes and developing their care and support plans.
• The service identified people's information and communication needs by assessing them. Staff understood the Accessible Information Standard. People's communication needs were identified, recorded and highlighted in care plans. These needs were shared appropriately with others. We saw evidence that the identified information and communication needs were met for individuals.

Improving care quality in response to complaints or concerns
• There was a complaints management system in place and complaints were responded to in a timely way.
• We saw complaints made by people or their family had been looked at promptly and carefully by the registered manager. The manager's responses sought to allay concerns and an apology was given when needed.
• Complaints were reviewed to see if they identified any ways in which the service could be improved more widely.
• People said they knew how to make a complaint, if necessary. Comments were, "Me and my brother would change to another company if they weren't up to standard", "I would get in touch with social services" and "Yes, the phone number (for the office) is on the cover of the care plan book."

End of life care and support
• There was no one receiving end of life care at the time of our inspection.

Good

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Good: The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

• Documentation of people's care was satisfactory. Care workers recorded what support they had provided to people during their call, how they greeted a person and what outcomes there were for people.

• Most care notes were comprehensive of the support provided. For example, "Greeted [the person] and assisted to the bathroom…left [the person] having breakfast in the lounge." Some care notes were recorded in a task-based method. One person's daily notes stated, "Full body wash, dried, sprayed (deodorant)."

• Where there were any issues which warranted management attention, these were highlighted by care workers promptly. There was evidence that the registered manager and nominated individual took responsibility and used duty of candour. For example, we saw two letters where the service offered an apology for an incident.

• There was an appropriate, up-to-date statement of purpose. This contained the aims, objectives and philosophy of care. This included, "Encourage clients or their representatives to participate as fully as possible in formulating their care plans" and "To meet the client's physical, emotional needs and overall well-being in a dignified, non-judgement way".

• A range of audits were completed to ensure that the service provided quality care in all aspects of support. The checks ensured that quality was promoted for the person, the relatives, staff and other stakeholders.

• Audits included the "care plan book". The field care supervisor completed the audit of people's care plan books every six weeks on a rolling basis. The findings of the audits were logged in an audit book for review by the registered manager. The registered manager explained they took actions where there were any areas identified for improvement. For example, during a team meeting the registered manager addressed the importance of a person-centre approach.

• Care documentation was also checked on a regular rolling basis. This included consulting the person who used the service and their relatives about the content, whether there were any changes or any requests for the support package.

• Spot checks of care workers' practice were completed every six weeks on a rotational basis. The field care supervisor checked for ID badges, presentation and punctuality, interaction with people and uniform.

• Medicines administration records were audited every six weeks to check for errors or omissions. Checks included legibility, correct signing and dating and any actions taken regarding medicines issues.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• People said the service was well-led. Feedback included, "Yes, it is. The manager looks after all the staff" and "Yes, I do because if there is hiccup, they will ring me to let me know if they are going to be late."

• Relatives felt the management of the service was good. They said, "They are reliable and caring" and "When I was in hospital, they came and cooked a hot meal for [the person] every day and they cleaned the house."
• There was a positive workplace culture at the service. Staff worked well together. They demonstrated that there was good interaction between staff who provided support to people and staff who were based in the office.
• One staff member stated, "The energy is a progressive energy…a lot of laughter. It's growing. There is a good amount of control, fairness and praise."
• The registered manager and nominated individual were dedicated and knowledgeable. They demonstrated they cared about the people who used the service, relatives and any significant others. There was a clear emphasis on growth of the service, quality of the care and exploring new ways of working.
• The management team were approachable and open to new ideas. Staff felt comfortable approaching the managers with their feedback or with any issues they wished to discuss.
• The management team had a very good understanding of regulation and the requirements set out in various legislation. They ensured the service, staff and care practices complied with various legislation.
• Regular meetings were held by the senior management team.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The service acted to protect people and staff from discrimination. The management team knew the requirements of the Equality Act 2010 and how people's individual differences may be considered protected characteristics. For example, the service respected people's and staff's gender and faith preferences. Human rights were upheld.
• The service sent a newsletter out to people and their relatives twice per year. The newsletter provided health advice and tips for people, telephone numbers for mobile hairdressers, physiotherapists and podiatrists.
• This ensured that people had access to information that would assist them in their care decisions and enabled people and relatives to call the office to discuss matters.
• A variety of meetings were held by the service with and between different staff groups. This included senior care workers, all staff and office staff (including the management team).
• Minutes of meetings showed how staff were engaged in the service and any changes and actions. There was evidence that discussion about lead roles (such as safeguarding and mental capacity) was included as a standing agenda item. Actions were clearly documented and the completion was recorded.

Continuous learning and improving care
• The provider had successfully delegated work and accountability for certain managerial tasks to their field care administrators and other office based staff. This enabled the managers to focus their time on other aspects of the service such as assessing the quality and safety of people's care.
• The service had implemented an electronic care record system. This was so that more contemporaneous and comprehensive notes or records could be completed and saved. The service continued to use some paper records but most of these were scanned and attached to people's and staff's electronic files.
• Staff meetings were used for points of learning. Minutes we reviewed showed staff were reminded about safety topics such as safeguarding, medicines, care plans and documentation, person-centred care. Any actions agreed between staff and management were agreed and there was evidence they were followed up.

Working in partnership with others:
• The service had a good relationship with local authorities and commissioners. Stakeholders we contacted told us they had no concerns about the service and that there was good communication with the management team.

• The service had commenced offering work experience to local high school students. This was available to pupils who wanted to experience social care work in the community.
• The service also employed a young adult staff member who wanted to gain experience in their first job. They required work experience to explore opportunities for apprenticeships. They worked in the office under the supervision of experienced staff members. The registered manager mentored the staff member and encouraged them to develop their skills and knowledge.