Artsermon Ltd

Bionicare (Domiciliary Care Agency)

Inspection report

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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?	Requires Improvement

Summary of findings

Overall summary

This inspection of Bionicare (Domiciliary Care Agency) took place between 22 and 24 January 2019 and was announced. The service was last inspected in March 2016.

Bionicare (Domiciliary Care Agency) is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older people, younger adults, children, people living with dementia, people living with a physical disability, people living with mental health disorders, people living with sensory impairments, people living with eating disorders and people living with learning disabilities or autistic spectrum disorder. On the day of our inspection there were 24 people using the service. Not everyone using Bionicare (Domiciliary Care Agency) received a regulated activity. CQC only inspects the service being received by people provided with 'personal care', help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There was a registered manager employed at the service. 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 rated the service good. At this inspection we found the evidence continued to support the overall rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

However, well-led was rated 'requires improvement' as the provider needed to make improvements to their quality monitoring processes. This was because action plans were not always put in place to monitor and improve the quality of the service following audits. Regular feedback was not collected from people and used to improve the quality of the service. Audits were not always effective at noticing where the service could be improved. People were unclear who the registered manager was. People and staff were positive about the management of the service.

Why the service is rated Good.

The service was safe. Systems and processes were in place to protect people from harm and abuse and staff understood these. People had risk assessments in place to mitigate the likelihood of harm. There were enough staff to ensure that people received care visits on time and for the correct duration. Staff had necessary pre-employment checks completed before working at the service. People were supported to take medicines safely. Staff had training and promoted good infection control.

The service was effective. People's needs were assessed before they started using the service. Staff had sufficient training and knowledge to support people. People were supported with their dietary needs and

healthy diets were promoted. People were supported to live healthy lives and were given information or supported to access health professionals where necessary. Staff received effective training to use equipment to support people. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The service was caring. People were treated with kindness, respect and compassion. People were involved, and able to make choices about the care they received. People's privacy, dignity and independence was promoted. Staff took the time to talk to people and build trusting relationships, and support people to achieve their wishes and goals.

The service was responsive. People received personalised care specific to their individual care needs. People's preferences, likes and dislikes were respected. Equality and diversity was a key value of the service and people's needs with regard to religion, culture and all other needs were met. Complaints were responded to promptly and the service checked that the complainant was happy with actions taken. People were supported with privacy and dignity at the end of their lives.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service requires improvement.	**Requires Improvement**

Bionicare (Domiciliary Care Agency)

Detailed findings

Background to this inspection

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

This inspection took place between 22 and 24 January 2019 and was announced. We gave the service 48 hours' notice of this inspection as the service is small and we needed to ensure that support was available for the inspection. This inspection was carried out by one adult social care inspector.

Before this inspection we reviewed the information, we held about the service such as notifications we had received from the registered provider. Notifications are when registered providers send us information about changes, events or incidents that occur at the service. We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

We spoke to three people who use the service, four relatives of people, three staff members, the care coordinator and the area manager. We also spent some time reviewing records. We looked at five people's care plans, three staff files and the staff rota system, and policies and procedures at the service. We looked at quality monitoring audits, minutes from team meetings, meetings with other professionals and documents which supported the training staff had received.

Good

Is the service safe?

Our findings

The service was safe. People felt safe and were protected from harm and abuse. One person told us, ''Yes, I feel safe. I would tell the staff if I did not.'' A person's relative said, ''(Relative) is safe because staff always talk and share information.'' Staff knew what to do if they suspected people were at risk of harm or abuse. Staff told us, ''I would document everything and go straight to my manager.'' and, ''I would whistle-blow and inform the safeguarding team or CQC.'' There was a record of safeguarding incidents and these were checked, with actions put in place to prevent incidents from happening again. We saw a safeguarding policy and posters around the office telling staff who to contact if they suspected harm or abuse.

Risks to people were assessed and updated regularly. People had risk assessments in place for medication, mobility, specific dietary needs and for their home environment. These told staff how to lower the level of risk when supporting people. Staff told us, ''Everything is assessed when a person starts using the service. Management update them but we let them know if there needs to be changes as well.'' New risk assessments were put in place, for example, when a person started using a new piece of mobility equipment.

There were enough staff and they were effectively deployed to meet people's needs. One person said, ''Staff are always on time. I cannot fault them really.'' Staff told us they had time to complete all their duties during care visits and had time to travel between visits. We saw the rota system used by the service and this ensured that the staff team fully covered people's care visits. The rota system alerted care coordinators to any care visits that were not covered. There was no way for staff to sign in and out of care visits using the current rota system. The area manager told us that they would be introducing a new system which would be more effective at detailing staff's arrival and departure at care visits. The care co-ordinator explained that people either lived with a relative or had two staff members attend their visits. The relative or other staff member would alert the management team if someone did not attend for a visit. We saw that there were plans in place to cover missed visits and that any missed or late visits had been covered by the existing staff team or the management team.

We reviewed staff files and saw that safe recruitment practices had been followed. There were some gaps in employment history which had not been accounted for. This was rectified by the area manager during our inspection.

People were supported to take medicines safely. One person told us, ''Staff are always on time to remind me about my medicines.'' Staff received training in medicine administration and knew how to administer medicines safely. Staff told us, ''I always check the care plan and MAR chart to make sure medicines are correct.'' A medication policy was in place which detailed the procedure to administer medicines. Medication administration record (MAR) audits were completed to ensure that errors were not made and staff received medication competency assessments. People who were prescribed 'as and when' needed (PRN) medication did not have protocols in place to administer theses medicines, however, there were plans to implement these.

Staff received training in infection control and knew how to prevent and control infection. People told us staff were always well presented and kept their homes clean and tidy. Staff told us, ''We need to be clean ourselves to show people how important it is. We always wear PPE (personal protective equipment).'' Policies and procedures were in place to prevent infection and staff had access to adequate amounts of PPE.

Lessons were learned when things went wrong. The area manager told us, ''It is all about communication between us, staff and the people we support.'' Incidents were logged and necessary action was taken to prevent incidents re-occurring. We saw that learning from incidents was shared with people and the staff team. For example, a person was losing weight and extra care visits and monitoring charts were put in place for the person.

Good

Is the service effective?

Our findings

The service was effective. People's needs were assessed before they started using the service. These assessments detailed the support people would need and their likes, dislikes and preferences. Care plans were produced with people following the assessment to ensure that their support needs could be met. The area manager and care co-ordinator said that they would not accept admissions if they could not meet the needs of the person.

Staff had the training, skills and knowledge to support people. A relative told us, ''[Staff] are great. They support [relative] with mobility equipment and know exactly what they are doing.'' One person told us, ''They do not start looking after me until they have the training.'' Staff told us they received training in areas such as safeguarding, moving and handling, and infection control. The care coordinator had a qualification to train the staff team in moving and handling. Staff also received training in specific areas such as dementia and autism. Staff who supported children received separate safeguarding training specific to children. We looked at a training record and staff files and saw that staff training was completed regularly.

Staff received induction before starting their job role. One staff told us, ''I shadowed experienced members of staff. We had lots of time to go through policies and care plans to get to know people.'' Staff received supervision and said that they found these supportive. Supervisions covered training and professional development. Staff members who did not hold a qualification in health and social care were supported to complete the Care Certificate, a set of standards which taught necessary skills for their job role.

People were supported to eat and drink according to their needs. One person told us, ''I get the best of both worlds because I eat what I want but [staff] help me cook new things safely.'' One staff told us, ''We should encourage and support people. This helps with a balanced diet.'' Care plans and risk assessments detailed people's specific dietary needs and information was available to staff about how to support a healthy diet. For example, one care plan often reminded staff to 'offer [Person] refreshments.' A dietician had been consulted to help complete care plans where appropriate.

The service worked well with other organisations and people were supported to access healthcare services. One person told us, ''If we have appointments then staff will support us.'' The care co-ordinator told us, ''If there are any problems then we get in contact with the GP or the district nurse.'' People's care plans told staff the signs to look out for that would mean a health professional, such as a continence or tissue viability nurse would need to be contacted. Contact details for health professionals were clear in people's care plans. Health appointments and any changes were documented and people's care plans were updated where necessary.

Although equipment was not provided by the service, staff had training in moving and handling and using the equipment. One relative of a person told us, ''They always check [relative's] hoist before using it.'' People had a 'home risk assessment' completed when they started using the service. This risk assessed the environment for the safety of people and the staff supporting them.

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 the mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA and saw that it was.

People or their relatives had signed consent forms in care plans to say that people had agreed to the support they received. People told us, ''[Staff] never do things unless I want it done.'' and, ''[Staff] always ask me before they do something.'' Staff had good understanding of the MCA and told us, ''If people cannot decide we need to help them and give them suitable options and choices to understand the decision.'' Where people did not have capacity, we saw that capacity assessments and best interest decisions had been completed. Care plans reminded and encouraged staff to ask for consent throughout people's daily support and routines such as personal care.

Good

Is the service caring?

Our findings

People were treated with kindness, respect and compassion. People told us, ''[Staff] are lovely. So, kind but very professional at the same time.'' and, ''[Staff] are more like friends than carers.'' Staff told us, ''It is important to talk to people and earn their trust.'' and, ''I put myself in [Person's] position. We might be the only person they see all day so it is important to take time to chat and ask how [person] is.'' When we visited the office site, we saw care coordinators and the area manager talking to people on the phone in a kind and friendly manner. A relative told us that staff would often attend for a person's care visit early if the person had requested to do an activity like walking the dog. Care plans prompted staff to ask questions such as, 'How was your morning?' and staff confirmed that they did this.

The area manager was proud of the fact that visits to people were 30 minutes at a minimum. The area manager explained that this gave staff time to sit and talk to people rather than just being task-orientated. People told us, ''[Staff] always have time to talk to me.'' and, ''[Staff] have a lot of time to chat to me.'' Staff confirmed that they had plenty of time to sit and talk to people during care visits.

People were supported to make choices about their care. One person said, ''Staff take on board what I want and always do things how I want them to be done.'' A relative told us, ''[Staff] always give [Person] a choice in how they want to do things.'' Staff had good understanding of how to support people with choices. Staff said, ''We never assume what a person wants. We always ask even if a person has had something the same way for a long time.'' People's care plans contained information about when and how to give people choices.

People's care plans were detailed and had information on how people liked to be supported, as well as their likes and dislikes. Care plans also had information about people's hobbies and interests, as well as information about their past lives. People told us that staff knew how to support them and knew what they liked. For example, specifically what towel to use during personal care. There was a policy in place detailing people's rights to advocacy, dignity, privacy and respect, with guidance for staff to follow.

People's privacy and dignity was respected. One person told us, ''[Staff] are there when I need them but in the background if I want time to myself.'' A relative told us that their family member preferred their own company after being supported and that staff respected this. One staff told us, ''I never talk over people, and always give people plenty of space. I follow [Person's] lead.'' Care plans detailed when to give people privacy and dignity.

People's care plans detailed what people could do themselves to keep their independence. One person told us, ''I can still do some things myself and staff respect that.'' A relative said, ''They let [Person] do as much as they can before stepping in to help.'' Staff confirmed this.

Good

Is the service responsive?

Our findings

People received care that was responsive to their needs. People had care plans in place for specific needs such as specific dietary requirements, risk of falls and keeping people independent at home. People, their relatives and relevant professionals were involved in creating care plans and updating them regularly or when needed. A relative told us, ''I am hugely involved. [Staff] consult me about everything.'' We saw that care plans were updated regularly as people's needs changed. For example, one care plan said that a person received less visits as their health had now improved. We saw that people's care needs were accommodated to suit their preferences.

People's preferences with regards to who supported them were followed. People received care from consistent staff. One person said, ''[Staff] are very consistent. They cover for each other so there are never many changes.'' We saw that people received support from staff based on their support needs and preferences. For example, some people only spoke a certain language. The management team ensured that these people only received support from staff who spoke the same language. We saw that information such as policies and procedures were available to people who spoke a different language. Two people we spoke with were involved in recruiting their own staff. The care co-ordinator showed us that people were sent their rota of staff visits in time to review them.

The management team and staff took people's equality and diversity very seriously. The area manager told us ''It (equality and diversity) is something we are passionate about. We want everyone to be treated as an individual.'' Staff told us, ''We put people at the centre of their care. Everyone needs something different.'' We saw policies and procedures in place detailing to staff how to support people with specific religious and cultural needs. People had 'ethnicity and religion' forms in place in their care plans. These detailed how to support people based on their chosen religion or culture.

People had access to a complaints policy. We saw that when complaints were made, they were responded to appropriately and promptly. People were asked if they were happy with the response to their complaint and actions were recorded for future learning. The care co-ordinator took the time to call people who made complaints to ensure people were still happy with the service being received. People and their relatives confirmed that when they had made complaints they were responded to, to their satisfaction.

People were supported with dignity and respect at the end of their life. The service was not supporting anyone at the end of their life at present. However, we saw that the service was prepared to do this and had done this in the past. Staff said, ''We make sure people are comfortable and have everything they need.'' Staff had received training in end of life care. We saw a written compliment from a relative that said, 'Thank you for the support to [person] especially in their last few weeks of life.'

Requires Improvement

Is the service well-led?

Our findings

The service was not always well-led. The registered manager was unavailable during this inspection. We spoke to the area manager and a care co-ordinator, who also supported us with the inspection process.

The service did not have clear plans in place to improve the quality of the service. Where improvements had been identified, actions were not always made, recorded or monitored. We saw that the service had recently received a monitoring visit from the local authority. This found several areas for improvements. However, there were no action plans in place to improve the service following this feedback. For example, it was identified that people did not have PRN protocols in place for medication. This had not been actioned at the time of our inspection. We reviewed people's PRN records and saw that PRN medications were being administered to people without protocols in place. The area manager explained that this was because people requested the medicines and showed us that there was a template to create PRN protocols for people. However, this showed that actions to improve the service based on feedback had not been put in place.

The service did not have a system in place to regularly collect feedback from people and put actions in place based on this feedback. People told us, ''[Management] ring up every so often.'' and, ''I cannot remember. It would be good to get rung up a bit more often.'' The area manager and care coordinator told us that they rang people and completed home visits regularly. However, records for this were inconsistent and did not record whether any actions were needed to improve the service based on people's feedback. We saw that a survey had last been completed for people who use the service in November 2017. This information was now over a year old and action plans had not been put in place and checked following the collection of this feedback. This meant that opportunities to improve the service based on people's feedback was being missed.

Audits were not always effective at ensuring that the service stayed in line with its own policies and procedures. For example, staff members did not receive supervisions and competency checks as regularly as stated in the policy. This meant that staff member's competency to complete their job role was not regularly checked. We saw audits of people's daily notes, care plans and MAR charts. There were no actions recorded on these audits, however one person had requested PRN medication every day for a month. This meant that potential changes to people's care was not being noted and actioned in audits.

People were not sure who the registered manager was. People we spoke with identified the area manager and care co-ordinators as the manager of the service. A relative told us, ''I speak to [area manager]. I think they are the manager.'' One person said, ''We only speak to [area manager] and [care co-ordinator]. Are they not the manager then?'' During our site visit it was clear that the area manager and care co-ordinators were very involved in the running of the service. People not being aware of who the registered manager was meant that the governance structure of the service may not be clear to people using the service.

We saw that there were plans in place to run the service at all hours of the day. An on-call system was in operation and a member of the management team were always on hand to deal with people's requests out

of working hours. There was a business continuity plan in place for events such as dangerous weather or staff not attending for visits.

The area manager was aware of their responsibilities. We saw that they had let us know, where they were required to do so, about events that happened at the service. We saw that there were policies in place around duty of candour, how to display ratings and when to let us know of events that had happened at the service.

Staff could contribute ideas towards the running of the service. Staff told us, ''We have team meetings every three months. I can say any improvements or changes I think might help.'' and, ''Our feedback is absolutely listened to.'' Staff were sent newsletters on a regular basis about what was happening at the service. We saw that the provider and the area manager rewarded and appreciated staff members. For example, staff received a bonus for working extra hours in severe weather.

The area manager spoke to us about plans to move the rota system over to a new electronic system to be more effective. The management team were moving records on to an electronic format to further improve efficiency. The area manager told us that they kept up to date with changes in legislation by receiving notifications from the CQC and other professional bodies. We saw that the area manager engaged with agencies such as the local authority and the Community Mental Health team.

The area manager and care co-ordinator told us that the values of the service were 'going above and beyond' and 'providing the best person-centred care possible.' These values were shared by the staff team who told us, ''Person centred care above all else and being creative with people's support.'' and, ''It is all about promoting dignity, respect and independence.'' Comments from people and relatives supported this.

People and the staff team were positive about the management at the service. One person told us, ''[Management] are very good. They are always on hand.'' A relative said, ''[Management] are brilliant. It is very well run.'' Staff told us ''[Management] are very easy to talk to. I have no problem approaching them.'' The area manager was also positive about the provider. They said ''[Provider] is in it for the right reasons. They genuinely care about people and staff.'' The area manager was very visible during our inspection of the service. The area manager was proud to work at the service and was committed to continuing to improve.