Braeburn Care Limited

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

Summary of findings

Overall summary

We inspected Braeburn Care on the 14 February 2017. The inspection was announced so that we could ensure people and records we would need to see were available. Braeburn Care is a domiciliary care agency registered to provide personal care for people who require support in their own home. The organisation is registered to provide care to people with a learning disability or autism spectrum disorder, dementia, older people and younger adults. At the time of our inspection Braeburn Care were providing care to 120 people who had a range of needs from old age, dementia and mental health. The service employed over 40 staff members.

There was a registered manager in post. 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.

People who received personal care and support from Braeburn Care told us they were happy with the service provided. One person told us, "The care workers are lovely, like my own daughters. I look forward to them coming and would not like to change a thing." Another person told us, "They are very good on the caring side, I feel happy with them."

People were supported with medicine management when needed and care workers had received training on how to administer medicines. However, we found unexplained gaps in Medication Administration Records (MAR) and people's medicine risk assessment did not always record the level of support required to safely manage their medicine regime.

Risk assessments were in place which considered moving and handling, however, risks associated with diabetes, falls and skin integrity had not consistently been explored or mitigated. We have made a recommendation for improvement.

Training schedules confirmed care workers had received training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). Care workers told us how they gained consent from people before delivering care. Consent forms were in place for people to sign to indicate their consent to the package of care and care plan. However, where relatives were signing consent forms, the provider was unable to demonstrate that they had appropriate authority to do so. We have made a recommendation for improvement.

People had individual care plans in place and care workers spoke highly of these. Information was available on the person's personal history and hobbies and interests. However, on-going work was required to ensure the principles of person-centred care planning were embedded into practice. We have made a recommendation for improvement.

A robust quality assurance framework was not consistently in place. Systems to monitor if care workers were staying the allocated times at care calls was not effective. Where care workers were not staying the allocated time, documentation failed to record the reason why. For example, although a care call was funded for 30 minutes, documentation reflected the care workers only stayed 20 minutes. People and their relatives raised no concerns over the timings of care calls and care workers not staying the allocated time. However, we have made a recommendation about a robust quality assurance framework which governs the running of the care agency.

People receiving support felt safe and well cared for. They were protected from harm because care workers understood the risks they faced and how to reduce these risks. They also knew how to identify and respond to abuse. Care workers were vigilant of people's health care needs and ensured they had access to health care professionals to maintain their health. Care workers understood the need to share information about changes in people's health.

There were enough safely recruited care workers to ensure the care could be provided. Care workers told us told us they felt supported in their roles and had received training that provided them with the necessary knowledge and skills to do their job effectively.

People were supported by care workers who were passionate about their work. Care workers told us they liked working for the organisation and appreciated that the organisation put people first.

People and relatives told us they felt able to raise any concerns with the registered manager. They felt these would be listened to and responded to effectively and in a timely way. Care workers told us the registered manager and senior staff were approachable and responsive to their ideas and suggestions.

Care workers were described as being caring and kind. Care workers respected people's decisions to make their own choices and supported people to maintain and develop their independence. One person told us, "Care workers enjoy what they do and go the extra mile and are cheerful, friendly and competent."

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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

Braeburn Care was not consistently safe.

People received their medicines from staff who had received relevant medicines training. However, information within people's records was not always up to date and a number of issues were found with the recording of medicines.

People told us they felt safe receiving care in their own home. Safe recruitment practices were in place and there were enough care workers deployed to meet people's needs safely.

Staff had received adult safeguarding training and were confident any concerns they brought up would be dealt with appropriately.

Is the service effective?

Good

Braeburn Care was effective.

People were always asked for their consent before care was given. People were supported at mealtimes to access food and drink of their choice in their homes and assisted where needed to access healthcare services.

People and their relatives felt confident in the skills of the care workers.

Is the service caring?

Good

Braeburn Care was caring.

Staff were caring and treated people with respect. People's privacy and dignity were maintained People told us they received care and support from care workers that were kind and caring.

People's confidentiality was respected and maintained.

People's regular care workers knew their preferences about their care and support.

Is the service responsive?

Good

Braeburn Care was responsive.

People's needs had been assessed and appropriate care plans were in place to meet their individual needs. Staff were provided with the information they needed to meet people's needs in a responsive manner.

People were confident they were listened to and any concerns they had were addressed

Is the service well-led?

Requires Improvement

Braeburn Care was not consistently well-led.

There was not a robust quality assurance framework in place.

The ethos, valued and vision of the organisation were embedded into practice. Care workers spoke highly about working for the provider and recognised they worked together as a team.

Braeburn Care Ltd

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 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.

This inspection took place on 14 February 2017. The provider was given 48 hours' notice of our visit because we wanted to ensure the registered manager was available to support the inspection. The inspection team consisted of 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. A member of the Care Quality Commission's (CQC) policy team also shadowed the inspection.

Before the inspection we reviewed the evidence we had about the service. This included any notifications of significant events, such as serious injuries or safeguarding referrals. Notifications are information about important events which the provider is required to send us by law. We also reviewed the Provider Information Return (PIR) submitted by the provider in August 2016. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we visited the agency's premises and spoke with the registered manager, the provider and five care workers. We checked care records for 13 people, including their assessments of needs, care plans and risk assessments. We checked four care workers recruitment files and other records relating to the management of the service, including staff training and induction, the complaints log and quality monitoring checks. As some people who received a care package from Braeburn Care were not able to tell us about their experiences, we observed the care and support being provided to four people with pre-obtained consent. During these home visits we were accompanied by a care worker. We also contacted two care workers via telephone after the inspection to gain their feedback.

This was the first inspection of the service since its registration with the CQC.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe with the care workers coming into their home and providing care. One person told us, "I feel completely safe; I have no concerns I have faith and trust in the care workers." One relative told us, "I know that (person's name) is safe in their hands." Despite people's positive comments, we found an area of care that was not consistently safe.

People confirmed that care workers supported them to take their medicine, apply cream or any pain-relieving patches. One person told us, "They help me with my tablets every day." Another person told us, "They are very good on medication; they put the tablets in my hand and watch me swallow them with a drink." Medicine risk assessments were in place which considered if people required support to administer their medicines or just prompting. Information was recorded on where people stored their medicines and who was responsible for re-ordering their medicines. However, despite individual medicines risk assessments in place we were not always assured that people who were supported with their medicines received them safely. For example, most Medication Administration Records (MAR) had been created by the agency rather than being supplied by the dispensing pharmacy. The registered manager told us, "We struggled to find a local pharmacy that will print MAR charts for us, so we have devised a new MAR chart which will prompt care workers to sign and initial the chart to confirm the transcribing instructions are correct." These records had not been signed by the care workers creating them nor had they been checked and signed by a second person for accuracy against the prescribed instructions. Recording on the MAR chart did not consistently document the full information on the medicines prescription label and often only noted the name of the medicine. This meant that people may not have received their medicines as prescribed and there was no system to check for accuracy or errors.

Individual MAR charts were brought back to the office once completed and the provider and registered manager confirmed these were reviewed for any omissions or gaps. However, not all MARs were subject to a formal audit. We reviewed a sample of MAR charts and found omissions with recording. For example, one person had a dosette box (medicine box with pre-packed tablets for specific times of the day) in place and staff were required to administer medicines from their dosette box three times a day. During the month of October 2016, we found 10 unexplained gaps on their MAR chart. One person's medicine risk assessment documented they did not require any support with their medicines. However, MAR charts were in place in their care plan confirming staff administered prescribed topical creams. Another person had a dosette box in place and took specific medicines to control their diabetes. A MAR chart was in place which also reflected that staff recorded when the person had taken their morning medicines. However, their medicine risk assessment failed to reflect this and lacked information on the person's diabetes and the importance of them taking their medicines.

We brought these concerns to the attention of the provider and registered manager who were open and responsive and during the inspection, started to implement a formal MAR audit process. However, medicines were not consistently managed in a way which ensured people received them in a safe and effective manner with regard for the risks associated with them. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's safety were assessed and care plans considered areas of care which presented as a risk. For example, health and safety risk assessments were in place which considered the internal and external environment of the home. These also considered the security of the home and if any pets were present in the household. People's care plans considered specific risks, such as risk of poor diet, dehydration or pressure sores. Information was available on the actions to mitigate such risks; however, this information was often limited. For example, where a person was identified at risk of malnutrition and dehydration. Actions to address this risk were, 'Care workers to prepare and encourage food and fluids.' Where people were diabetic, risk assessments failed to include information on the signs of high and low blood sugar or when to contact the district nurses. The registered manager told us, "Our care workers primarily support the same people, so they are aware of how to address risk and meets people's needs. For example, one person who is diabetic, if they are continually thirsting, that is a sign that their blood sugars may be low or high." It was clear that staff knew how to address and mitigate such risks, but these were not consistently recorded in people's care plans. One person was living with a chronic respiratory condition and was prescribed oxygen, they also smoked tobacco. Their risk assessment and care plan did not consistently identify related risks and information about when their smoke alarm was last tested and whether it was in working order was not recorded. We brought these concerns to the attention of the registered manager who agreed to amend the environmental risk assessment to include information on smoking and fire alarms. We have identified this as an area of practice that needs improvement.

We recommend that the provider seeks guidance from a national source on robust risk assessments.

Sufficient numbers of care workers provided a dedicated and consistent team for the person and ensured that they were safe and well cared for. The provider told us, "We only have 15 calls that do not have an allocated care worker. All of our care calls have allocated workers, so people receive care from a consistent team of care workers." Staffing numbers were determined by the number of hours of care commissioned, geographical areas and the individual needs of people. On the day of the inspection, Braeburn Care was providing 948 hours of care per week. The provider told us, "We are continually recruiting, so that we can assure ourselves all care calls are covered and if we accept new packages of care, we can safely meet people's needs." Care workers raised no concerns over staffing levels and felt staffing levels were sufficient to cover the care calls and meet people's needs.

Rotas were planned two weeks in advance and care workers were informed of the calls they would be covering via secure email. One care worker told us, "We received our rota on the Thursday, ready for the Saturday. It's also sent in the post." When visiting people in their own homes, they also confirmed they received a weekly rota, which informed them who would be coming and at what time." One person told us, "I always know who is coming; I have been having the same care workers for two years. They are like friends."

Care workers had been recruited through a recruitment process that ensured they were safe to work with adults at risk. Appropriate checks had been completed prior to care workers starting work which included checks through the Disclosure and Barring Service (DBS). These checks identified if prospective care worker had a criminal record or were barred from working with children or adults at risk. Care workers confirmed these checks had been applied for and obtained prior to commencing their employment with the service, and records confirmed this. As care workers were driving in the local community and accessing people's individual home through the use of their individual car, the provider had sourced appropriate documentation to confirm that care workers were safe to drive and had up to date car insurance and a valid Ministry of Transport (MOT) test certificate.

Care workers recognised the importance of leaving people's property secure at the end of a care call. One

care worker told us, "I go always go round and make sure all the windows are closed. Oven is off and the person has their lifeline to hand. I then make sure the door is closed and locked behind me when I leave." One person told us, "We have a 'keysafe' and the carers let themselves in and call out, 'hello, carers', then come on in. When they have finished and checked I do not need anything else they leave and lock up and put the key back ready for the next one(care worker)."

Staff had received appropriate training in safeguarding and were able to explain what kinds of abuse people could be at risk of, potential signs of abuse and what they would do if they thought somebody was at risk. One care worker told us. "I had concerns over the well-being of one person. I raised concerns with management and they took action straight away." Where safeguarding concerns had been raised, the provider worked in partnership with other agencies to ensure the safety of people and learning had been derived.

Good

Is the service effective?

Our findings

People commented that they felt confident in the skills and abilities of care workers. One person told us, "My carers are trained and skilled; I was a carer myself for 20 years, so I know they are. They know my routine and get on with it. I am happy with this and it works like clockwork, they always ask if there is anything more they can do before they leave me." A relative told us, "Carers are superb, they know how to deal with (person) and I would definitely say they were well trained."

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 when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

Training records demonstrated that care workers had received essential training about the principles of the MCA as part of their induction. They demonstrated a firm awareness of how to gain consent from people. One care worker told us, "I gain permission from people to go into their home, explain who I am and ask if they are happy for us to provide care." People and their relatives confirmed that they were always asked for their consent. Consent forms were available which included consent to the care plan implemented by Braeburn care. We identified that on occasions, these consent forms were signed by a relative. We explored with the registered manager whether these relatives had the appropriate authority to sign these consent forms, such as lasting power of attorney for health and welfare. The registered manager was confident that relatives did have the appropriate authority to be signing the consent forms. However, they acknowledged they had not seen the confirmation. Consideration had not also been explored as to whether the person lacked capacity and required someone to make this decision or sign the consent form on their behalf. One person's care plan provided by the local authority identified that a mental capacity assessment was required for each significant decision. However, we found no mental capacity assessments on file for this person. Other care plans we reviewed, did not contain this directive from the local authority. Although care workers understood the importance of gaining consent from people and training records demonstrated that training on the MCA 2005 was in place. The provider could not consistently demonstrate how the principles of the MCA 2005 were embedded into practice.

The provider and registered manager was responsive to our concerns and started to action immediately to action these concerns and make positive improvements. We recommend that the provider seeks guidance on how to implement the MCA 2005 Code of Practice.

Care workers undertook an induction and a variety of essential training which equipped them with the skills and knowledge to provide effective care. Upon commencing employment with Braeburn Care, care workers were subject to a probation period. This included shadowing care workers until it was deemed they were competent to work unsupervised. One care worker told us, "The shadowing was really helpful as I got to

meet and get to know the people I would be supporting." Care workers also completed a company induction. The provider had been working on improving the induction and training by incorporating the Skills for Care, Care Certificate into the induction and training for new care workers. The certificate sets the standard for new health care support workers. A variety of training was also provided to care workers via their inductions. Training included dementia, death and dying, infection control and confidentiality. Care workers spoke highly of the training provided and confirmed they felt the training equipped them with the skills required to provide effective care.

Mechanisms were in place to monitor and ensure that the training care workers completed was effective and implemented appropriately. Records demonstrated that care workers were subject to unannounced spot checks to ensure that their practice was competent and meeting the needs of the person. These spot checks enabled the registered manager to ensure care workers arrived to the care call on time, stayed for the duration of the care call, wore the appropriate uniform and ID badge; whether they treated the customer with respect and dignity, showed an interest in their wellbeing and effectively communicated with the person.

People were supported to maintain good health and have access to ongoing healthcare support. One person told us, "They seem to know what to do, they noticed a red area on my body and let the GP know, I am now having cream put on this area." Care workers said they checked how people were feeling and would always contact the office if they had any concerns about their health during a visit. One care worker told us, "I recently went to a person whose respiratory condition had exacerbated and they couldn't catch their breath, so I called 999 and stayed with them until the ambulance arrived." Care workers confirmed that in the event of 999 being called, they would always remain with the person until the ambulance crew arrived. Where people used specialist moving and handling equipment, input and guidance from the occupational therapist and physiotherapist was available within the care plan.

Where required, care workers supported people to eat and drink. Much of the food preparation at mealtimes had been completed by family members or people themselves and care workers were required to reheat and ensure meals and drinks were accessible to people. One care worker told us, "When preparing food and drink, I always offer people a choice and let them decide what they want to eat. When leaving a care call, I always make sure they have a drink to hand." When visiting people in their own homes, we observed that care workers offered people a choice of hot drink and involved them in making decisions about what they wished to eat. One person told us, "(Care workers) makes a very good cup of tea."

Good

Is the service caring?

Our findings

People were satisfied with the care they received and said they saw regular consistent staff who knew them well and treated them with kindness. Care workers confirmed they saw people on a regular basis which enabled them to build them rapports with people. One care worker told us, "They keep us in our geographical area so we get to know people and go to them every day." With pride, care workers told us about the people they supported. One care worker told us, "I just love working with the 'clients' and getting to know them. I work with one person who is just so funny. They have the best sense of humour and they always make sure we're ok. We always say we are there to support her but she always likes to check we're ok also. It's lovely."

People confirmed their dignity and privacy was always upheld and respected. Care workers were aware of the need to preserve people's dignity when providing care to people in their own home. Care workers we spoke with told us they took care to cover people when providing personal care. They also said they closed doors to ensure people's privacy was respected. One care worker told us, "I always make sure that doors are shut. Dignity and respect are very important." Another care worker said, "I always make sure that people are covered when I'm doing personal care".

Care workers recognised the importance of promoting people's independence. People confirmed they felt care workers enabled them to have choice and control whilst promoting their independence. One care worker told us, "I always encourage people to do things for themselves. For example, I might say to one person, go on have a go and I'll be here if you need me." Another care worker told us, "I support people to the bathroom where I get the water ready and say I'll be outside if you need me."

People's confidentiality was respected. Care workers understood not to talk about people outside of their own home or to discuss other people whilst providing care for others. The staff's rotas were securely sent to them with details of their visits to undertake. Information on confidentiality was covered during care workers induction and training.

Care and support was provided to a number of people living with dementia in their own homes. Care workers told us how they provided kind and compassionate care and understood how to support people's individual care needs. One care worker told us, "We covered dementia care in our induction and I find that patience is the key." Another care worker told us, "When supporting people with dementia, I find it's important to get to them to know and their routines. I support one person who can get agitated and distressed but I found by implementing a routine, they know what to expect and this eases their agitation."

People were given a lot of information both verbally and in writing on what to expect from the service and how they could make contact with the office staff and registered manager. People said they knew who to speak to if they wanted to discuss their care plan or make a change to it.

Relatives and people spoke highly of the caring nature of the care workers. One person told us, "They are very good, kind and caring, we have a laugh and they cheer me up." Another person told us, "They are very

good on the caring side, I feel happy with them." Relatives spoke highly of the care workers confirming that the care workers enhanced their loved one's well-being and they looked forward to their visits. One relative told us, "They love my (family member) to bits and are so kind and caring, my (family member) has got to know them and thinks the world of them; my (family member) says they are like daughters."

Good

Is the service responsive?

Our findings

People received care from care workers who were knowledgeable about their care needs, preferences, likes and how best to support them. One person told us, "I feel as if I am treated as an individual, they know what I need them to do." People told us that they had a good relationship with the care workers and could have a laugh and joke with them.

Assessments were undertaken to identify people's support needs and care plans were developed outlining how these needs were to be met. Care plans considered general information such as access to the property, the person's health, their personal history and their hobbies and interests. Information was also available on the tasks required at each specific care call and the duration of that care call. For example, one person had a thirty minute care call every morning. The care plan included information on the tasks required, such as supporting the person to have a bath or shower. This provided the care workers with a clear overview of the level of support and tasks required at each care call. Care workers told us they found the care plans helpful and informative. One care worker told us, "I've worked for other companies and the care plans are pages long and you have to read streams of pages to find the information you need. However, with Braeburn Care, the care plans are succinct and easy to follow."

Care plans included information on people's hobbies and interests and personal history. However, we found this information was brief. Personalised care planning is at the heart of health and social care. It refers to an approach aimed at enabling people to plan and formulate their own care plans and to get the services that they need. Personalised care plans consider the person's past, their life story, their wishes, goals, aspirations and what's important for them when receiving care. Steps had been taken to personalise care plans, however, there was limited information on what was important to the person and how to provide care that promoted the person's independence. For example, what they could do for themselves. From talking with care workers, it was clear they had spent time getting to know people and knew people well but further work was required to make care plans person centred.

We recommend that the provider seeks guidance from a national source about the implementation of person-centred care plans.

We visited four people in their own homes. Care workers were observed reading the person's care plan and daily notes before providing any care. They told us it was important to read the care plan to check for any changes and to ascertain how the person's last care call was.

People and their relatives told us that the service was responsive to their concerns and suggestions. People confirmed that their preference for male or female care worker was upheld. One person told us, "I was asked about a male carer and I said I preferred not." Where people had not formed a positive working relationship with a care worker and requested that they did not support them again, their preference had been upheld and respected.

People and their relatives confirmed they felt able to express their views, opinions or raise any concerns.

One person told us, "If I had any worries, I would contact the office but I haven't needed to." Information on how to make a complaint was provided to people when they first started receiving care and people confirmed they felt any complaint would be dealt with and acted upon. The complaints policy was also accessible to people within their homes, as a copy was available in their care plan. The policy set out the timescales that the organisation would respond, as well as contact details for outside agencies that people could contact if they were unhappy with the response. The information provided to people encouraged them to raise any concerns that they may have. The provider had received two complaints in the last year and we saw that these had been responded to in a timely and thorough way to the complainants' satisfaction.

Since Braeburn Care opened two years ago, the provider had received a wide range of compliments from people and their relatives. A recent compliment received from a relative was, 'I would like to say a big thank you to your team of carers, they were absolutely superb, kind and friendly.'

Requires Improvement

Is the service well-led?

Our findings

People, relatives and care workers spoke highly of the provider and registered manager. People and their relatives confirmed they all knew the registered manager and confirmed they felt she did her best to provide them with continuity of care from their preferred care workers. One relative told us, "I am totally satisfied, we get personal service and I would definitely recommend it." Whilst all feedback about the management was very positive we found the leadership of the service was not effective in all areas.

The system to monitor and identify whether people received their support on time and for the agreed support time was not always effective. An electronic system was not in place, therefore the provider was reliant upon care workers recording the start and end time of care calls on the person's daily notes and recording accurately on the time sheets returned to the office. We looked at a sample of daily notes and found some discrepancies with recording. For example, one person's daily notes between the period 1 October 2016 and 20 October 2016 reflected that care workers had not recorded the times of the care call on five different occasions. Another person was funded for three thirty minute care calls per day. We reviewed their daily notes between the periods 17 December to 29 December 2016 and found on 10 occasions, the care workers only stayed for twenty minutes. We found this was a consistent theme within the daily notes we viewed. This meant the provider was unable to demonstrate and evidence that care workers were staying the allocated time. We discussed these concerns with the provider and registered manager. They told us, "We review the daily notes and time sheets for any discrepancies and concerns. For example, we identified one care worker who was always late to their morning call. After discussion with them, we agreed for them to have care calls in the afternoon and evening as they confirmed they found it hard getting up in the morning." Although daily notes and time sheets were being reviewed, a formal audit template had not been put in place for the provider to evidence that these shortfalls had been identified and how they were addressing these concerns.

Care workers confirmed that at times people did not wish them to stay the full allocated time and if they finished early, they would always ask if there's anything else they could do before leaving a care call. However, documentation failed to reflect this. Therefore, the provider was unable to provide a robust audit trail of why care workers were not staying the allocated time at care calls.

People received care from a consistent team of care workers; however, we found that the timings of people's care calls could vary. Individual care plans did not always record the specified time of the care call so it was not always clear what time the care workers should be arriving. For example, one person was funded for one care call a day for 45 minutes. We reviewed their daily notes for the period of 9 December 2016 to 1 January 2017. We found that the start of their morning call could vary between 06.50am and 10.10am. Between this period, we also found that the care workers arrived at a different time every day. Another person was funded for a morning call for an hour and half. Their daily notes reflected that the start of their morning care call could vary between 09.30am and 11.40am. Another person's daily notes also reflected that their morning call could vary between 07.10am and 09.55am. Despite these varying times in care calls, people and their relatives had not raised relevant concerns. One person told us, "I get the same carers and rota telling me who is coming." People and their relatives also confirmed that care workers stayed the allocated time and

always asked if there was anything else they could do before leaving. The provider told us, "Some people's call times vary as they fit around the capacity of the care worker they have built the best rapport with. We work with people to ensure they receive care from care workers they get along with and sometimes this involves variation in the times of care calls." However, documentation failed to reflect this. We have identified this as an area of practice that needs improvement.

Care plans were subject to a care plan audit. However, we found this audit framework was not consistently effective. For example, one person's care plan stated they received one care call daily. However, their daily notes dating back to October 2016 reflected that they had been receiving three care calls daily. The registered manager confirmed that after a hospital admission, their package of care had increased but acknowledged their care plan had not been updated to reflect this change. After person's daily notes referenced that they had a catheter in situ, however, this was not reflected within the body of the care plan. Despite these omissions, people told us they received the level of care required and care workers confirmed they were informed of any changes to the person's care package before visiting them. We also queried with the provider and registered manager what other audits they completed. Audits are a quality improvement process that involves review of the effectiveness of practice against agreed standards. Audits help drive improvement and promote better outcomes for people. The provider told us, "We complete care plan audits and review the daily notes and MAR charts but don't record on a formal audit template." The absence of a robust quality assurance framework meant the provider had not consistently identified the shortfalls which the inspection process noticed.

The failure to operate a robust quality assurance framework is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Systems were in place to obtain feedback from people which was used to help drive service improvement. Satisfaction surveys were sent out on an annual basis and feedback was received from care workers, people and relatives. The results of the satisfaction survey from January 2016 identified both positive feedback and areas for improvement. One consistent theme from the feedback was that people were not informed if there was a change to the allocation of their care worker. Following this feedback, the registered manager implemented a call sheet which recorded every time a care worker was changed and how this was communicated to the person.

There was an emphasis on team work and communication sharing. Information sharing was thorough and care workers were encouraged and had time to discuss matters relating to the delivery of care. One care worker told us, "I feel valued and they always listen to any suggestions or concerns I have. For example, I was worried about one person and I informed the office. Within a couple of days they have reassessed the person."

People, relatives and care workers spoke highly of the management and felt the service was well-led. One relative told us, "Care workers enjoy what they do and go the extra mile and are cheerful, friendly and competent." One person told us, "I would thoroughly recommend to anybody, they are wonderful." One care worker told us, "I really enjoy working for Braeburn Care. They are responsive to my concerns and they always put the customer first." Another care worker told us, "They really look after their staff. After my first day, they phoned to see how I was, which I thought was thoughtful."

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider did not ensure that medicines were being managed safely. Regulation 12 (2) (g).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that there were effective systems to assess and quality assure the service. Regulation (17) (1) (2) (a) (b)