Bangladeshi Parents and Carers Association

Bangladeshi Parents & Carers Association

Inspection report

St Margaret's House
21 Old Ford Road
London
E2 9PL

Tel: 02088807036

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service caring?	**Inspected but not rated**
Is the service responsive?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

This inspection took place on 29 October 2018 and was announced. This was the first inspection carried out since the service registered with the Care Quality Commission in October 2018.

'Bangladeshi Parents & Carers Association' is a domiciliary care agency. It provides personal care to people living in their own homes in the community and provides a service to older people and people with learning disabilities. The organisation provides two day services but this is not regulated by CQC. At the time of our inspection one person had been using the service for five months. We were able to carry out an inspection but we could not rate the quality of the service as we had insufficient evidence on which to do so.

The service had a registered manager. 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.

The provider had systems in place for assessing risks to people using the service, but these did not always result in a clear management plan.

The service operated safer recruitment processes to ensure staff were suitable for their roles. People told us that their care worker usually arrived on time and they were contacted if they were running late for any reason.

Care workers did not provide support to people with their medicines in their homes, but due to their work in the day service had training and experience in this area. There were systems in place to monitor medicines but records of support were not designed in a way which could be easily audited or provide the right information for care workers.

People using the service knew what care they needed to receive and told us that they received this as planned. The person using the service was consistently supported by the same care worker who understood their needs well. The provider had not developed their own care plans for people and relied on the local authorities plans, which were task-centred and lacked personal details.

There was a policy for providing information in a way which met people's needs, but only some documents were available in community languages. Care workers spoke the same language as people and their families and understood their cultural needs.

Care workers received the right training in order to meet people's needs safely and received supervision from managers. There were suitable processes in place to safeguard people from abuse and improper treatment. People knew how to complain about the service and there was a process that allowed an external body to oversee a complaint when necessary. There were processes in place to record when things

had gone wrong but these did not include a clear way of recording learning from accidents and incidents and actions to prevent a recurrence.

Managers had systems in place to monitor the quality of the service but these were not fully implemented with regards to the domiciliary service. Due to the small size of the service we were unable to judge their effectiveness.

We were unable to provide a rating for this service. We will continue to monitor the development of the service and will carry out a further inspection in six months' time.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

We did not have sufficient information to rate the service's safety.

The provider assessed risks to people's wellbeing but did not have clear management plans in place. Staff understood their responsibilities to safeguard people from abuse.

The service operated safer recruitment measures and there were enough staff to meet a small, simple care package.

There were processes to record when things had gone wrong but there had not been cause to use these.

Is the service effective?

Inspected but not rated

We did not have sufficient information to rate the service's effectiveness.

Assessments of people's needs sometimes lacked detail. Care workers received suitable training and supervision to carry out their roles.

There were processes in place to assess people's capacity to consent to care.

Is the service caring?

Inspected but not rated

We did not have sufficient information to rate whether the service was caring.

People benefitted from having care workers that spoke their language and understood their culture. People told us they were treated respectfully. People consistently received care from the same care worker.

Care plans were not sufficiently developed to reflect people's wishes and preferences for their care.

Is the service responsive?

Inspected but not rated

We did not have sufficient information to rate the service's responsiveness.

The provider had systems for identifying people's outcomes and goals for their care, but these were not yet in place. Care was delivered as planned. Records of care didn't record how people were and how their needs and wellbeing had changed.

People were able to make complaints but had not had cause to do so.

Is the service well-led?

Inspected but not rated

We did not have sufficient information to rate whether the service was well led.

There were systems of oversight in place but these had not been fully applied to the provider's domiciliary care service.

There were suitable policies and procedures for the organisation to operate effectively and regular team meetings where these were discussed.

The provider sought people's views about the service.

Bangladeshi Parents & Carers Association

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.

Why we inspected - this was a routine first inspection. We inspect new services within 12 months of their first registration. We had not received any information of concern about this service.

This inspection took place on 29 October 2018. We gave the provider two working days' notice of the inspection because the service is small. We needed to be sure key members of staff were in.

The service was carried out by an adult social care inspector and an assistant inspector who was a Bengali speaker. We spoke with the registered manager, deputy manager, administrator and one care worker. We looked at records of recruitment and supervision for two care workers and records of care and support for the person who used the service. We spoke with the person who used the service and a family member at the day service.

Inspected but not rated

Is the service safe?

Our findings

We did not have sufficient evidence to rate the safety of the service. The service had measures in place to help ensure people's safety, however due to the limited number of people who had used the service, we could not see enough evidence to demonstrate that these were being implemented to protect people from avoidable harm.

The provider had a policy relating to safeguarding adults from abuse. This included staff responsibilities to report abuse and processes to record these. Policies included contact details for the local authority and how staff could whistle blow in the event concerns were not acted on. A care worker we spoke with told us they received training in safeguarding adults and demonstrated a knowledge of their responsibilities to record suspected abuse and report these appropriately. The care worker was confident that managers would take this seriously but in the event they did not were confident in reporting concerns to the local authority themselves.

The provider had carried out assessments which identified risks to people using the service. These were comprehensive in their scope and included risks from the person's living environment, those from repositioning and making transfers and how health conditions could impact on the person's safety. However, we found that these assessments did not lead to risk management plans where risks were identified. The assessment had not identified any serious risks to the person's wellbeing. A care worker detailed risks to the person using the service, such as slipping on a wet bathroom floor and the actions that they took to mitigate these. After the inspection the provider supplied a detailed risk management plan that they had put in place in response to our feedback. This included specific risks to the person, precautions care workers took to prevent these and actions to be taken in the event of a specific hazard occurring.

At present there was only one member of staff working in domiciliary care, but another member of day service staff could cover if necessary. People signed off their timesheets to verify that care workers had stayed for the correct time. A family member told us "If [our care worker] is running late they will phone… there has never been any need to call, but if they didn't arrive I could call the office."

Care workers were recruited in line with safer recruitment processes. This included obtaining references of satisfactory conduct in previous employment and obtaining proof of people's identity and right to work. The provider carried out checks with the Disclosure and Barring Service (DBS) before staff started work. The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions.

The provider was not currently supporting anybody with their medicines. Care workers had received training in how to do this and there were suitable policies in place to ensure medicines were safely managed. The provider told us that care workers across the service received refresher training every year. There were processes for recording when medicines had been refused and when errors had taken place. The provider showed us the recording sheets they used in the day service and would use in people's homes. These sheets recorded which medicines were administered each day and did not use a standard format. This meant that

managers would not be able to tell whether a medicine was signed for each day and therefore would be difficult to audit. The format also lacked key information about dose and dispensing instructions for care workers to follow. The provider told us they would revise this system in the event they started providing support with medicines and after the inspection showed us a more effective system they had developed for recording medicines.

The provider had systems in place for recording when incidents and accidents had taken place. These included details of what had happened, any injuries that had occurred and who had been informed. However, this did not require managers to identify actions and learning that had taken place because of the event. However, no serious incidents or accidents had taken place since the service had started providing care.

Inspected but not rated

Is the service effective?

Our findings

The provider's assessment was used to assess people's support needs. This included assessing people's daily living skills, such as what aspects of personal care people could do for themselves and whether people required support to wash and dress and prepare food. Assessments identified the support people's families provided in areas such as managing medicines and providing food and drink and any training that care workers required. A more detailed assessment of the person's needs was carried out by the day service, including information on health conditions that may affect their support, but this information was not designed with domiciliary care in mind and was over six years old, which was not helpful in planning the person's care.

Care workers underwent an induction on starting with the service and there was a checklist of key points which was completed and signed off by a manger. Care workers received training to a minimum of a level two diploma in health and social care and managers obtained copies of certificates of courses they had attended elsewhere. Care workers could discuss their training needs in supervision. The provider told us "We have inductions and observations of competency and until we are confident they are able to provide care we don't let them do anything else." A care worker told us "Of course we get good support on how to support people and training as well...we get practical support in how to use a hoist, everything is practical."

Care workers had regular supervisions with their managers. This included discussing policies and procedures, planned work, updates on people's wellbeing and support, safeguarding, reporting incidents and accidents and the completion of daily logs.

A care worker told us of how the person's health conditions may impact on their daily living skills, but there was insufficient information on risk assessments to judge this. People's ability to prepare food was assessed but the service did not regularly support people with nutrition and hydration.

The provider had policies and procedures to comply with the Mental Capacity Act (2005) (MCA). The Act 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. The provider was not supporting anybody who lacked capacity, but had systems in place to assess people's capacity to make particular decisions and to demonstrate that they were working in the person's best interests.

The person using the service did not have a care plan and had therefore not indicated their consent to care, however they were clear with us that care was provided in line with their wishes.

Inspected but not rated

Is the service caring?

Our findings

People told us they were treated with dignity and respect, but we had insufficient evidence to judge whether the service was caring.

A care worker demonstrated a good understanding of the person's needs and wishes for their care and how they promoted decision making, telling us "It's always [his/her] choice, not my choice." The person had consistently received support from the same care worker on each visit since June.

People did not have clear personalised care plans provided from the service. The local authority care plan was largely task orientated and centred around what needed to be done on each visit and what support people required, including support from family. There was no plan in place that contained personal information such as people's preferences for their care, their interests and how best to provide emotional support, although the care worker we spoke with demonstrated a good understanding of the person's needs.

The absence of plans meant there was limited information on how care workers could best support people to communicate. However, people and their families told us that care workers spoke their language and understood their cultural needs. A family member told us ""They have the cultural respect and a bit of conversation make [him or her] more comfortable." The provider told us "All our staff speak English, Bengali and Urdu".

Inspected but not rated

Is the service responsive?

Our findings

Systems of care planning and review were not well developed and due to the small size of the service we were unable to rate the service's responsiveness.

The provider was not using their own care plans, and care workers were using the plans supplied by the local authority. A care worker told us that this document was useful and easy to follow. The person using the service had not seen the local authority care plan but knew what care was to be provided by the service. The care worker understood what was expected from each care visit and how the person's needs could vary depending on their family's ability to support them.

Although the care plan in use served its purpose and was a recent document, using the local authority's plan meant that the provider would not be able to take into account the findings of their own assessment and risk assessment processes and would not be able to alter a care plan if the person's needs or wishes for their care changed.

The provider showed us an example of the care plan format that they intended to use in future. This was based around identifying outcomes for people who used the service and how these could be met, and included regular review to measure progress towards meeting people's goals. After our inspection, the provider showed us how they had applied this format to planning with the person they were supporting.

Care workers kept records on the care they had provided. These showed that care was delivered as planned, but recording was usually brief and did not show how a person's needs or relevant health conditions may have varied.

The provider was partially meeting the Accessible Information Standard (AIS). The AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with the AIS.

There was a policy in place for how the service should meet people's needs for accessible information. This included examples of accessible support plans and documents and some information was provided in the relevant community languages. However, assessments did not routinely highlight when people had accessible communication needs. People told us that their care plans were not available in community languages.

The provider had a procedure in place for investigating and responding to complaints. This included a clear timescale for responding to complaints. The provider had a management committee who could investigate a complaint if the complainant was not happy with the response. The provider told us "We have external procedures, so when people make complaints it may go elsewhere [if necessary]". There was no flow chart in place for how to respond to complaints and the procedure lacked detail about how the provider could ensure that people were happy with the outcome.

People and their families told us they had not had cause to complain but knew who to speak to if they needed to.

Inspected but not rated

Is the service well-led?

Our findings

The service had suitable systems of governance and oversight in place, but it was too early in the development of the service to gauge their effectiveness. The day service still represented the majority of the provider's work. The provider had not yet extended their systems to cover oversight of the small domiciliary service.

The provider told us they had not been trying to extend the service at present as they had been rebranding to make the service more accessible to all. The registered manager told us, "It did start off as a Bangladeshi service but we want to be open to everyone...we have people from many different communities." Managers told us that they had not faced any significant challenges as yet.

The provider discussed policies and procedures in supervision and staff meetings. At this point they did not have separate staff meetings for the domiciliary care service. Staff meetings took place regularly, and were used to discuss issues such as activities, any concerns about people using the service and staff responsibilities. Meeting minutes were provided in an outcome based format so that actions could be recorded and followed up.

A care worker told us "[My manager] will do the spot check on the communication books, my manager will give me advice and guidance." It's like a family here, I'm happy." The provider didn't check the quality of care plans. Managers told us they wrote action plans in place on people's files which served as support plans, but on checking with colleagues determined that this was not in place for the person they were supporting. The provider told us they would put one together as soon as possible. The provider told us they hadn't yet carried out a formal spot check of the person's care, but the family using the service told us they had received two visits from managers to make sure things were going well and were also monitored by their social worker.

The provider told us they carried out checks of people's files, but this was mostly in the day service, and that they spoke with families to make sure they were in place. Additionally, both local authorities had carried out audits of the service.

The provider monitored staff movements using a tracking system. This was used to make sure that staff members and vehicles were in place, but could also be used to verify whether care workers had arrived at people's homes as planned.

The provider had systems in place to seek feedback from people using the service. This was done in a user friendly way. The form asked people to answer questions with either "always", "sometimes" and "rarely" and the example question was "Are you awesome?" People were asked if their care workers arrived on time, respected their wishes and treated them with dignity. People were also asked if they were contacted by office staff, whether they knew how to make a complaint and whether they knew the contents of their care plans.