Bicester PA and Care LLP

Bicester Innovation Centre

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?	Good

Summary of findings

Overall summary

We undertook an announced inspection of Bicester PA and Care LPP on 9 November 2017.

Bicester PA and Care LPP is a domiciliary care service providing personal care for people in their own homes in Bicester, Oxfordshire and the surrounding area. At the time of our inspection 26 people were being supported by the service.

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.

We were greeted warmly by staff at the service. The atmosphere was open and friendly.

People told us they benefitted from caring relationships with the staff. There were sufficient staff to meet people's needs and people received their care when they expected. Staffing levels and visit schedules were consistently maintained. The service had safe, robust recruitment processes.

People were safe. Staff understood their responsibilities in relation to safeguarding. Staff had received regular training to make sure they stayed up to date with recognising and reporting safety concerns. The service had systems in place to notify the appropriate authorities where concerns were identified.

Where risks to people had been identified risk assessments were in place and action had been taken to manage the risks. Staff were aware of people's needs and followed guidance to keep them safe. People received their medicine as prescribed.

Staff had a good understanding of the Mental Capacity Act (MCA) and applied its principles in their work. The MCA protects the rights of people who may not be able to make particular decisions themselves. The registered manager was knowledgeable about the MCA and how to ensure the rights of people who lacked capacity were protected.

People were treated as individuals by staff committed to respecting people's individual preferences. The service's diversity policy supported this culture. Care plans were person centred and people had been actively involved in developing their support plans.

People told us they were confident they would be listened to and action would be taken if they raised a concern. We saw a complaints policy and procedure was in place. The service had systems to assess the quality of the service provided. Learning was identified and action taken to make improvements which improved people's safety and quality of life. Systems were in place that ensured people were protected against the risks of unsafe or inappropriate care.

Staff spoke positively about the support they received from the registered manager. Staff supervision and meetings were scheduled as were annual appraisals. Staff told us the registered manager was approachable and there was a good level of communication within the service.

People told us the service was friendly, responsive and well managed. People knew the managers and staff and spoke positively about them. The service sought people's views and opinions and acted upon them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were sufficient staff deployed to meet people's needs.

People told us they felt safe. Staff knew how to identify and raise concerns.

Risks to people were managed and assessments were in place to manage the risk and keep people safe. People received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

People's needs were assessed and care planned to ensure it met their needs.

People were supported by staff who had the training and knowledge to support them effectively.

Staff received support and supervision and had access to further training and development.

Staff had been trained in the Mental Capacity Act 2005 (MCA) and understood and applied its principles.

Is the service caring?

Good

The service was caring.

Staff were kind, compassionate and respectful and treated people and their relatives with dignity and respect.

Staff gave people the time to express their wishes and respected the decisions they made. People were involved in their care.

The service promoted people's independence.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and gave clear guidance for staff on how to support people.

People knew how to raise concerns and were confident action would be taken.

People were treated as individuals and their diverse needs respected.

Is the service well-led?

Good

The service was well- led.

The service had systems in place to monitor the quality of service.

The service shared learning and looked for continuous improvement.

There was a whistle blowing policy in place that was available to staff around the service. Staff knew how to raise concerns.

Bicester Innovation Centre

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 on 9 November 2017 and was announced. We told the provider two days before our visit that we would be coming. We did this because the registered manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that someone would be in. The inspection was carried out by an 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.

Before the inspection, the provider completed a Provider Information Return (PIR). This 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. We looked at information we held about the service. This included previous inspection reports and notifications we had received. Notifications are certain events that providers are required by law to tell us about. In addition we contacted the local authority commissioners of services to obtain their views on the service.

We spoke with eight people, three relatives, four care staff, the administrator, the deputy manager and the registered manager. During the inspection we looked at six people's care plans, four staff files, medicine records and other records relating to the management of the service. We also contacted the local authority commissioner of services for their views.

Good

Is the service safe?

Our findings

People told us they felt safe. People's comments included; "I do feel safe in their presence and they're friendly" and "Not a worry, I feel I am in safe hands". One relative commented about a person being supported to attend a local day centre. They said, "I know they get him there safely".

People were supported by staff who could explain how they would recognise and report abuse. Staff told us they would report concerns immediately to their line manager or the senior person on duty. Staff were also aware they could report externally if needed. Comments included; "I would report any concerns to [registered manager] and I could call the GP or the local authority", "I would contact my manager straight away. I can call CQC (Care Quality Commission) as well" and "I'd go to my manager". The service had systems in place to report concerns to the appropriate authorities.

Risks to people were managed and reviewed. Where people were identified as being at risk, assessments were in place and action had been taken to manage the risks. For example, one person could not bear weight on their legs. The person used a 'ceiling track hoist' to transfer to their wheelchair which they used to mobilise. Staff were provided with guidance on how to safely transfer this person. This included, the use of correct moving and handling techniques, positioning of the sling and reassuring the person during the transfer. Staff were also guided to ensure the person's home was free from 'clutter, hazards and obstructions'. This ensured the person had freedom of movement around their home.

Another person was independently mobile but had a history of falls. The person's home was equipped with hand rails to assist the person to mobilise if they became unsteady on their feet. Staff were guided to be vigilant when the person was mobilising and check the person had suitable footwear and remind them to use the handrails. Staff we spoke with were aware of, and followed this guidance.

People were protected from risks associated with infection control. Staff had been trained in infection control procedures and were provided with personal protective equipment (PPE). 'One person had a percutaneous endoscopic gastrostomy (PEG) (feeding tube placed through the abdominal wall and into the stomach) tube for medicines and fluids'. Staff had been trained in managing this condition safely and were provided with detailed guidance relating to the risk of infection for this person. This included using 'PPE as intended' and 'observing good hand hygiene at all times'. An up to date infection control policy was in place which provided staff with information relating to infection control. This included; PPE, hand washing, safe disposal of sharps and information on infectious diseases.

We spoke with staff about infection control. Their comments included; "I had the training, it was really good. We have no problems with equipment, there is always gloves and aprons", "We have everything we need with PPE. We are well equipped" and "We are all trained and up to date regarding infection control and the care plan guidance is clear".

There were sufficient staff deployed to meet people's needs. Staff visit records confirmed planned staffing levels were consistently maintained. Where two staff were required to support people, we saw they were

consistently deployed. People told us staff were punctual and they experienced no missed visits. People's comments included; "They come about 9.30, that's just fine. They only go when they've finished" and "They turn up bang on time, most of the time". One person told us how the service informed them if staff were running late. They said, "I always get a phone call if they're going to be late or sometimes to ask if I mind if they come a little early, if it helps them".

Records showed the service had two missed visits during 2017. Both had been investigated by the registered manager and established people were not placed at risk. The results of the investigations concluded staff had miss-read the staff rota. The registered manager took action to reduce the risk of reoccurrence. The issues were discussed with staff at meetings and the importance of following visit rotas were emphasised. One staff member also received 'advice and guidance' through a supervision meeting. There had been no missed visits since the last incident in September 2017. The registered manager recorded and monitored late visits to look for patterns and trends.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the service. These included employment references and Disclosure and Barring Service (DBS) checks. These checks identified if prospective staff were of good character and were suitable for their role. This allowed the registered manager to make safer recruitment decisions.

Medicines were managed safely. Records relating to the administration of medicines were accurate and complete. Where people were prescribed medicines with specific instructions for administration we saw these instructions were followed. For example, where people received their medicine through an external tube (PEG). Staff responsible for the administration of medicines had completed training and their competency was assessed regularly to ensure they had the skills and knowledge to administer medicines safely. Staff we spoke with told us they had received medicine training and were confident supporting people with their medicines. One staff member said, "I've had medicine training and I've no issues with medicines at all. My competency has been checked, we are always monitored". Another staff member said, "I help some clients with medicines. My training is up to date and my competency has been checked". One person said, "They (staff) make sure I take my tablets".

Good

Is the service effective?

Our findings

People's needs were assessed prior to accessing the service to ensure their needs could be met. People had been involved in their assessment. Care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. For example, one person's care plan stated '[Person] enjoys lots of sensory play, photos, videos and music'. Another person had a pet dog. During our inspection this person visited the office with a staff member. The person told us they had been shopping for dog food and treats. This person told us, "[Staff] take me shopping to get things for my [dog's name], it is wonderful". It was clear from the conversation the staff member had detailed knowledge of this person, what the person liked and how they wanted to be cared for.

People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, one person had difficulty verbalising. The care plan detailed the person's preferred communication methods. The plan stated, '[Person] understands plain English'. It went on to state, [Person] will point at the things he wants or will turn his head or push away things he doesn't want'. In addition the care plan highlighted the person did 'not like to be ignored' or the word 'no'. Staff we spoke with were aware of this guidance.

People told us staff knew their needs and supported them appropriately. Comments included; "Excellent, I just cannot fault them, absolutely brilliant", "They all know what they're doing and all know what my needs are" and "I can't fault them at all". Relatives also commented on the effectiveness of staff. Comments included; "My mum's house was a tip and smelled when we started with Bicester PA but after only a few weeks I've noticed it's getting into much better shape" and "These visits are so very, very helpful for my mother".

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Staff told us they received an induction and completed training when they started working at the service. This training included safeguarding, moving and handling, dementia and infection control. Induction training was linked to the Care Certificate which is a nationally recognised program for the care sector. Staff also shadowed an experienced member of staff before being signed off by the registered manager as being competent to work alone. Staff spoke with us about their training. Staff comments included; "The training here is good, and we get refresher training", "The training is all fine, I am right up to date" and "No complaints about the training. It does give you confidence". Training records were maintained and we saw planned training was up to date. Where training was required we saw training events had been booked.

Staff told us and records confirmed staff received support through regular supervision (a one to one meeting with their line manager). Staff comments included; "I get 100% support both in and out of work. This is the best company I have worked for", "I am supported and I can contact [registered manager] whenever I want" and "I am supported and there is always someone to ask if I need. I get supervisions and I've asked for further training in palliative care. I am going on the course soon". Staff were also supported through

'observation of care practice'. Senior staff observed staff whilst they were supporting people. Observations were recorded and fed back to staff to allow them to learn and improve their practice. Observations were also fed into staff supervisions. These measures ensured staff had the skills, knowledge and experience to deliver effective care and support.

We discussed the Mental Capacity Act (MCA) 2005 with the registered manager. 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. The registered manager was knowledgeable about how to ensure the rights of people who lacked capacity were protected. For example, one young person did not have the capacity to decide where to live. A meeting was held to consider this person's best interests which included the young person's parents, a social worker, healthcare professionals and the registered manager. The person's best interests were fully considered and included the need for an 'independent mental capacity advocate' (IMCA) whom we saw had now been appointed.

Staff demonstrated an understanding of the MCA and how they applied its principles in their work. Staff comments included; "Clients best interests must come first. It is about respecting their wishes and decisions. I offer choices" and "If someone has difficulties with a decision I offer choices and work in their best interests"

The service sought people's consent. Care plans contained documents evidencing the service had sought people's consent to care. These were signed and dated by the person or their legal representative. Staff told us they sought people's consent. One staff member said, "I never do anything without the client's permission".

Most people did not need support with eating and drinking. However, some people needed support with preparing meals and these needs were met. People either bought their own food or families went shopping for them. People had stipulated what nutritional support they needed. For example, one person's care plan stated 'breakfast, a cup of milky tea, two slices of toast and a banana'. Staff were also reminded to leave the person with 'fresh water with lemon or lime'.

One person had been assessed as having 'compromised swallowing'. This person had been assessed by a speech and language therapist (SALT) who recommended the person required a 'soft moist diet cut into bite sized pieces. Meat should be shredded and mixed with sauces'. Daily notes evidenced the staff supporting this person followed this guidance. No one we reviewed was at risk of dehydration or malnutrition.

The service worked closely with other professionals and organisations to ensure people were supported to maintain good health. For example, staff often attended medical appointments with people when they requested and the registered manager liaised with an NHS Trust relating to arrangements for a person being discharged from hospital to establish support could be safely and effectively provided on discharge. Various professionals were involved in assessing, planning and evaluating people's care and treatment. These included people's GPs, SALT, opticians, dentists NHS Trusts, social services and district nurses. Details of referrals to healthcare professionals and any advice or guidance they provided was recorded in people's care plans. Information was provided, including in accessible formats, to help people understand the care available to them.

Good

Is the service caring?

Our findings

People told us they benefitted from caring relationships with the staff. Comments included; "I have a good laugh with them and I hate to see them go", "They come in each time, every day and do anything I want. They are good and I can't knock them at all", "The carers are all very nice" and "I love them to bits, they do an awful lot for me". One relative commented, "They are far more professional and far more caring than our previous care company".

Staff spoke with us about positive relationships at the service. Comments included; "I love my work and my clients are great", "I've worked in care for 15 years and I love my clients and the variety of work" and "I love it here, we all help each other and I love the clients".

Staff were supported by the service to provide emotional support for people. The registered manager told us, "Staff don't just provided physical support, they provide emotional support that promotes the person's well-being. Just sitting and chatting or having a cup of tea can make a huge difference in a person's life". Daily notes evidenced staff interacted with people beyond physical support. For example, one person's daily notes recorded 'all's well, person cheerful today. Had a chat and a cup of tea'. Another person's family member died and they asked if the registered manager would accompany them to view the body. The registered manager attended.

People told us they received emotional support. One person said, "They would do anything for you at all". Another commented, "They (staff) take me out, chat to me and make tea". One relative told us how the person had memory loss and could not tell them what staff had done for them. This sometimes caused the person distress as they could not remember. The relative said, "They (staff) leave little notes for me for when I visit at weekends, on what tasks they've done, cleaning, washing and the like".

People's dignity and privacy were respected. When staff spoke about people to us or amongst themselves they were respectful and they displayed genuine affection. Language used in care plans was respectful. Staff used people's preferred names.

People told us they were treated with dignity and respect. One person said, "I do have different carers and they are polite and chat to me". Another person said, "There have been no problems (with dignity) ever".

We asked staff how they promoted, dignity and respect. Comments included; "I treat my clients as I would wish to be treated" and "I put towels over people to protect them and I always explain what we are doing. I close blinds and I shut doors, it keeps it all private".

People were involved in their care and kept informed. Daily visits schedules and details of support provided were held in people's care plans. Where there were any changes to scheduled visits people were informed by telephone. For example, if a different staff member was attending to the one the person expected the person would be called informing them of the change.

People had been involved in the creation and updates of their care plans. Staff met with people and their families and sought their input into how care plans were to be created and presented. People's opinions were recorded and incorporated into the care plans. For example, people provided personal information for their 'personal profile' section of the care plan. People chose how much information to disclose and discussed with the registered manager how they wished this information was to be presented. We saw people's wishes were respected and each person's personal profile was different.

Staff promoted people's independence. One person's care plan noted they were independently mobile until they developed a serious illness. The person recovered from the illness but their mobility had been impaired. Records showed how staff had worked with, encouraged and supported the person to eventually become independently mobile again. One staff member commented, "I encourage them to do what they can for themselves. The longer they stay independent the better".

The service was compassionate. Staff identified one person living with dementia would sometimes scratch their hands if they became bored. The registered manager made the person an 'activity apron'. This apron, worn by the person featured various items with contrasting colours and textures sown into the fabric which allowed the person to 'fiddle' and interact with which reduced their boredom and prevented injuries to their hands. The person's care plan contained photographs of the person smiling and proudly wearing their apron.

The service ensured people's care plans and other personal information was kept confidential. People's information was stored securely at the office and we were told copies of care plans were held in people's homes in a location of their choice. Where office staff moved away from their desks we saw computer screens were turned off to maintain information security. A confidentiality and data protection policy was in place and gave staff information about keeping people's information confidential. This policy had been discussed with staff.

Good

Is the service responsive?

Our findings

People were assessed to ensure their support plans met their individual needs. Staff were knowledgeable about people's needs and told us they supported people as individuals, respecting their diversity. For example, one staff member said, "One person I care for is not English so I take more time explaining things for them whilst maintaining their dignity. This client is quite religious and likes to talk about their religion. I make a cup of tea, listen and join in the conversation. They seem to appreciate that". Another staff member commented, "Everybody is different and we have spoken about people's diversity as a team".

Staff treated people as individuals. For example, one person had difficulty hearing and could become confused. Staff were guided to communicate with the person by 'speaking clearly and make sure you are looking at the person'. This was the person's preferred method of communicating. Another person liked to have a 'ready meal' left in the refrigerator in case they became hungry after staff had left. Daily notes evidenced this person's individual preference was respected. One person told us, "[Staff] is caring and very flexible. She will do anything for you".

People's diverse needs were respected. Discussion with the registered manager showed that they respected people's different sexual orientation so that gay and bisexual people could feel accepted and welcomed in the service. They told us, "We have an equality policy that reflects our commitment to people's diverse needs. We welcome everyone to the service as an individual". The equality policy covered all aspects of diversity including race, sex, sexual orientation, gender re-assignment and religion. Records showed staff had received training in equal opportunities and diversity.

The service was responsive to people's changing needs. For example, when people had medical or private appointments they were able to adjust care visit times to suit their needs. We also saw that where people's condition changed the service responded by making referrals to healthcare professionals and adapting care and support to meet the person's changing needs. For example, one person returned home after a long spell in hospital and required hoisting as they had lost their mobility. With encouragement and further recovery, the person's mobility greatly improved. We were shown a video of this person mobilising with their family. The person had consented to the video. We spoke with one person about their changing needs and how staff responded. They said, "[Staff] suggested I phoned my GP to look at my legs. This was purely because she (staff) was interested and noticed (a change)".

People knew how to raise concerns and were confident action would be taken. Everyone we spoke with knew how to raise a complaint and felt they were listened to. One person said, "In the folder they have all the contact numbers of everyone and everything I might need and detail of what needs to be done. Things like how to complain". Another person said, "I know if there is a problem that they would react to it".

The service had systems in place to record, investigate and resolve complaints. The service had received one complaint in 2017 which had been resolved in line with the provider's complaints policy. Details of how to complain were held 'information packs' provided to people and their families.

People's opinions were sought and acted upon. The provider conducted regular quality assurance surveys where people and their relatives could express their views about all aspects of the service. We saw the results for the 2017 survey which were extremely positive. The registered manager investigated any issues raised by the survey and took action. For example, one person raised an issue relating to professional boundaries with a staff member. Following investigation the registered manager resolved the issue through the disciplinary procedure.

Where people approached the end of their life the service worked with healthcare professionals and the person's family. We saw some staff had been trained in palliative care and these staff were deployed to support people at end of life. For example, one person was cared for in their home at end of life. The person received specific pain relief and staff were trained by the district nurse to safely administer this medicine. This ensured the person did not have to wait for a healthcare professional to receive pain relief. Staff provided emotional support and were present, with the family, when the person died. The registered manager said, "It was great comfort to the daughter that staff were present when [person] died. He was a lovely man".

Good

Is the service well-led?

Our findings

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 we spoke with knew the registered manager and felt the service was well run. Comments included; "We tend to get a regular carer in the morning and we often get the bosses at the weekend too", "Yes, I've seen [registered manager], she's very nice", "They're always polite and [registered manager] and [deputy manager] come to me too". One relative said, "My wife is getting so much better with their (service) assistance. [Registered manager] and [deputy manager] are here quite a lot. [Deputy manager] deals with any problems and it is not only caring but she has lots of ideas too". During our inspection one person arrived at the office. They were greeted warmly by the registered manager and office staff and the person clearly knew them all and engaged in friendly conversation.

Staff told us they had confidence in the service and felt it was well managed. Comments included; "[Registered manager] is very good, approachable and she works very hard. This is an open and honest service with no culture of blame at all. I think it is very well run", "[Registered manager] is really accommodating and supportive. It's a well-run service that has a really positive culture. The staff matter and it feels that way", "My manager is very good, she always wants the best and her door is always open" and "This (service) is very well run with good approachable management. We don't have a blame culture here".

The service had a positive culture that was open and honest. Throughout our visit management and staff were keen to demonstrate their practices and gave unlimited access to documents and records. Both the deputy manager and the registered manager spoke openly and honestly about the service and the challenges they faced.

We spoke with the registered manager about their vision for the service. They said, "I want this to be a good service for all our clients where they are treated as individuals. I want them to look forward to the care worker coming to support them". Our findings detailed in the other areas of this report demonstrate that the staff were currently working in accordance with this vision.

Accidents and incidents were recorded and investigated. The results of investigations were analysed by the registered manager to look for patterns and trends. They were also analysed to see if people's care needed to be reviewed. Reviews of people's care included referrals to appropriate healthcare professionals. For example, the registered manager identified a pattern relating to falls and as a result referrals were made to an occupational therapist and staff received specific training. The registered manager told us, "Our new computer system is now online and this will allow us to analyse information so much more easily. It will provide the overview for the management of all aspects of our quality assurance processes".

The registered manager monitored the quality of service provided. Regular audits were conducted to

monitor and assess procedures and systems. Information from these audits was used to improve the service. For example, following an audit of care notes it was identified one person was presenting a change in their behaviours. Further investigation identified the person had contracted an infection that affected their behaviour. We saw all staff were briefed and a discussion took place on how to effectively support the person. Another audit identified recording errors with medicine records. Having established people had safely received their medicine staff were provided with advice and guidance and we saw the accuracy of records had improved.

Staff told us learning was shared at staff meetings, briefings and through an electronic messaging service. People's care was discussed and staff could make suggestions or raise issues. For example, at one staff meeting it was discussed how one person's 'stockings' required washing at the last visit of the day. This ensured the person had a minimum of one pair of clean stockings for the following day. One staff member said, "The messaging 'app' is very handy, I can pass messages amongst the team confidentially. If I am on leave I can catch up any time and arrive back at work fully informed". Another staff member said, "We text each other using the messenger. We put information in people's daily notes and we have meetings where we can talk about changes to people's needs and raise issues ourselves. Communication is very good".

The service worked in partnership with local authorities, healthcare professionals and social services. We contacted the local authority commissioner of services and asked for their views. We were told, "Bicester PA and Care are very good. When we use them they are pro-active and accommodating at all times".

There was a whistle blowing policy in place that was available to staff across the service. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.