BJP McMorrine Limited

Right at Home Central London

Inspection report

Millbank Tower
21-24 Millbank
London
SW1P 4QP

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26 February 2018
27 February 2018

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30 April 2018

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

This inspection took place on 26 and 27 February 2018 and was announced. We gave the provider 48 hours' notice of the inspection visit because the manager could be out of the office supporting staff or providing care. We needed to be sure that they would be in. This was our first inspection of the service since the provider registered with the Care Quality Commission (CQC) in February 2017.

Right at Home Central London is a domiciliary care agency that provides personal care to people living in their own houses and flats in the community. It provides a service to adults and younger people with physical disabilities, sensory impairments and people living with dementia. At the time of the inspection eight people were using the service.

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The service had 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 were helped by staff to prepare their meals and were sufficiently supported with their nutrition and hydration. Medicines were safely managed and the staff who administered medicines had been trained to do so. The registered provider worked together with health professionals to ensure appropriate health provision was accessed by people.

Recruitment checks were carried out on staff before they were employed by the provider. There were enough staff deployed to meet people's needs. Staff received training and briefings on equality, diversity and human rights which provided them with the skills and knowledge to carry out their roles. Staff received support from the registered manager and had the opportunity to discuss their individual performance needs during supervisions and appraisals.

People told us that staff were caring, respectful and courteous. Staff knew people well, what they liked and how they wanted to be cared for. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Information about safeguarding was in place and staff understood how to recognise signs of abuse and knew whom they would report their concerns to. Risks had been assessed and reviewed when people's needs had changed.

People's needs were responded to and care tasks were carried out thoroughly by staff. Care plans contained person centred information to support people with their individual needs and their needs were being met. People knew how to raise a complaint and these had been investigated and resolved. The provider was not currently supporting people who were at the end of their end of life but there were plans in place to provide

end of life care training for staff so that they could provide this support if required.

People, their relatives and care workers told us the service was well run. Feedback was sought from people to improve the quality of care. The provider worked in partnership with other health care providers and held memberships with a number of professional organisations. Audits to monitor the quality of the service provided were completed and identified the areas that required improvement. Actions were put in place to address these issues.

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.

Staff knew the correct action to take to keep people safe from harm and abuse. Risks assessments were up to date and reviewed to reflect changes in people's needs.

Pre- employment checks were completed to ensure that staff were suitably vetted to work with people using the service.

Protocols were followed to ensure the safe management of medicines.

There was enough staff to support people with their care. Staff attended their call visits to people's home on time.

Is the service effective?

Good

The service was effective.

Risk's to people's health and wellbeing were identified and action was taken to address this.

Staff received the appropriate training and support to deliver good standards of care to people.

Staff supported people with their nutritional needs and the provider worked with healthcare professionals when this was required.

Decisions were made in people's best interests and involved health and social care professionals.

Is the service caring?

Good

The service was caring.

People and their relatives told us they were supported by caring and considerate staff.

People were supported to express their views and be actively involved in making decisions about their care.

Staff provided care to people that protected their dignity and privacy.

Is the service responsive?

Good

The service was responsive.

Person centred care plans were developed and included people's lifestyle choices and how they wished to receive their care.

The provider had a strong commitment in relation to raising awareness about equal rights for people.

Suitable processes were in place to deal with complaints and these were managed effectively.

Is the service well-led?

Good

The service was well-led.

People and their relatives spoke positively about the provider. Systems of audits were completed to identify any shortfalls within the service.

The culture of the service was open and transparent and the provider adopted a 'hands on' approach to help people receive the right care.

The provider worked in partnership with other external providers of care and was knowledgeable about changing legislation in health and social care.

Right at Home Central London

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 was a routine first inspection of the service since the provider registered in February 2017.

We inspected Right at Home Central London on 26 and 27 February 2018. We gave 48 hours' notice of the inspection because staff could be out of the office supporting staff or visiting people in their homes and we needed to be sure that someone would be in. The inspection was announced on the first day and we told the provider we would be returning to continue with the inspection for a second day.

The inspection was carried out by one adult social care inspector. An expert by experience made telephone calls and spoke with two people and one relative to seek their views about their experience of using the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We checked information that the Care Quality Commission (CQC) held about the service including any notifications sent to CQC by the provider. The notifications provide us with information about changes to the service and any significant concerns reported by the provider. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

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We visited the office location and spoke with the compliance manager, the managing director and owner and the registered manager. We reviewed five people's care files and two people's medicines records. We

also checked four staff training and recruitment records, quality audits, minutes of meetings and some of their key policies and procedures.

After the inspection we made telephone calls and spoke with 10 care workers and managed to speak with three of them to obtain their views about the service.

Good

Is the service safe?

Our findings

People told us the reasons why they felt safe using the service. One person said, "I feel very safe; the carer has become a close friend. [The care worker] is very kind and a friendly helpful person; you couldn't ask for anybody nicer." And a relative commented, "The carers are mature, they arrive on time and tend to [my family member]. They follow a step by step process to put [them] at ease."

A service user guide was given to people when they began to using the service. Information about safeguarding was contained in the guide. This informed people about what safeguarding was and held details of the contact numbers of the external agencies that people could report safeguarding concerns to. This meant that people had information to show them what to do if they had concerns about their safety.

Staff were familiar with the provider's safeguarding procedures and knew who they could contact if they suspected people were at the risk of abuse. Training records confirmed that all staff had received safeguarding training. There had been no safeguarding concerns raised and the registered manager understood their responsibilities of reporting safeguarding concerns if these arose. A whistleblowing procedure was in place for staff that included details of the external organisations they could report any wrong doings to that they witnessed.

Risks assessments were detailed and contained information about people's individual needs. These had been reviewed when people's needs changed. The assessments identified the risks associated with people's medical needs, their mental and physical health and safety in their homes. They included instructions on the actions that staff were required to take to manage the risk. For example, a risk assessment about a person's pressure area care included details about the written observations that staff were required to record about the person's skin integrity and the equipment used to mitigate the risk. The records we checked showed this was being acted on.

An environmental risk assessment was completed that looked at a range of areas in people's premises including fire detection equipment and the use of space to accommodate equipment and adaptations in people's rooms. Guidance was in place so that staff could follow the correct procedure on what they should do if there were concerns about access and safety arrangements in people's homes, for example, the no response procedure. The no response procedure is for situations when staff are unable to gain access to a person's home so care workers know what to do, to ensure their welfare.

The provider spoke with us about their recruitment process. They showed us information about how they assessed candidates competency for their role. The provider used an assessment tool to check applicant's values and the reasons why they had applied for a care worker role. They said this helped to recruit caring staff with the right attitude and values that were needed in the care sector. We reviewed the staff recruitment records and found they had the correct evidence to show that the staff employed were suitable to work with people who used the service. Background checks on employees had been carried out and included references, photographic identification and criminal records checks.

People and their relatives told us that staff arrived for their care visits on time and that there was enough staff to provide support when this was needed. One person said, "Staff do arrive and leave on time; they inform me if they're running late." A relative explained that they had no cause for concern about the punctuality of the care workers said there were enough staff to provide care when this was needed.

The staff we spoke with told us that they had enough time to care for people and that they were given enough travel time between calls, and commented, "That is one good thing. The travelling time is really good and the times are really spread out." The provider monitored the hours staff worked through the use of an electronic call monitoring system. They used this to check if people arrived and left their care visits on time and to monitor care worker's health and safety. For instance, records showed that the registered manager had discussions with a person who had live in care workers. They had mutually agreed to allocate more staff to the person's rota. This was to ensure that staff had sufficient rest breaks as required by law to make certain that people received appropriate and safe care.

People told us they were supported appropriately with their medicines. Staff had received training in the safe management of medicines. Information evidenced that staff had signed and dated people's medicines records to show they were given as prescribed. Care plans outlined detailed information about the type of medicines people took and if their relatives were involved in supporting them with this area of their care. For one person, a review of their medicines had taken place after the person requested to manage their own medicines after this had been agreed by the GP. Following this, the provider reviewed and updated the person's medicines risk assessment to ensure that staff checked during their visit that there were no tablets being left around that were unaccounted for.

Personal protective equipment was stored in the provider's office such as aprons and gloves that staff collected and used to maintain infection control when this was required.

Incident and accident records were maintained and attached to accompanying body maps. These showed what had happened and how incidents had been investigated. Referrals had been sent to health and social care professionals to report incidents when this was required. We saw records to show that following a complaint that the provider had ensured that lessons were learnt about how to manage the person's care package more effectively.

Good

Is the service effective?

Our findings

People experienced positive outcomes in relation to their health and wellbeing. A thorough assessment of people's needs was undertaken to check the provider could meet their individual needs. Care plans were produced in line with good practice guidance and showed how people reached their goals. Records evidenced that following an assessment of a person's needs the provider had identified that their home environment did not safely meet their needs. This led to the provider drafting an action plan with the person and their representative of the things that needed to be put in place. They liaised with an occupational therapist to ensure that suitable equipment was ordered and fitted. The registered manager contacted another healthcare provider that they knew to source a short term placement for the person whilst decorating was taking place and adaptions were being made to their home. The registered manager explained the person was worried about their cat whilst they were away from their home. The provider organised for the person's neighbour to take care of the cat and made plans for the neighbour to take the cat to visit the person in their short-term placement. But the neighbour changed their plans and was unable to do this. This showed the provider aimed to achieve effective outcomes for people to maintain and enhance their quality of life.

Essential training was completed by staff to equip them with the skills and knowledge necessary to provide effective care. A care worker commented, "The training was interesting; when I started I hardly had any experience and the training was really good. I still attend training because you are never too experienced to learn something new." Records showed that an appropriate induction was attended by care workers followed by a period of shadowing with a more experienced member of staff. We were shown the training programme and checked the training matrix. This demonstrated that staff had access to learning and development which was provided throughout the year on a rolling basis so that all staff were able to attend. We looked at the training materials which included topics on the subjects that staff had completed. This included up to date training on moving and handling, basic life support, food hygiene, medicines, pressure area care and health and safety.

The provider told us that care workers were offered an incentive when they had completed their probationary period. Some staff had completed the Care Certificate as part of their induction. The Care Certificate is a set of minimum standards that should be covered as part of induction training for new care workers. Regular supervision and one to one and group meetings had been attended by care workers to discuss their skills and practice and the areas they could improve. Where care workers had been working for more than one year we saw that an appraisal had been undertaken to review the performance of the employee in line with the provider's procedures.

People were supported to have sufficient food and drink provided by staff if it was part of their assessed care needs. A relative told us that care workers prepared the food and that their family member could eat and drink without staff support.

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People's food choices and preferences were documented in their plans. For one person, their records indicated that they enjoyed going shopping to a particular store to buy their essential groceries. Nutrition

and hydration plans included a risk assessment for another person and evidenced they had difficulty consuming their meals. The records showed they required soft food and that the person had a healthy appetite. For a third person their plans demonstrated that their shopping was delivered and records showed that the fridge was well stocked with enough groceries. A fourth person's records showed that staff were required to ensure that the person must be sat in an upright position in a certain chair to support them effectively with their meals. The daily records we checked showed that this was being followed.

People had accessed healthcare facilities and were given advice and support about their medical needs by health practitioners. Medical advice was sought when people needed treatment and support with their health conditions. Care plans evidenced that the registered manager had discussions with people about how the staff should support them with their visual and hearing impairments, communication, personal care, mobility and their skin routines during an assessment of their needs.

Written notes about people's health needs were recorded and monitored. Where one person suffered from seizures, we found that there was a timeline of when these occurred along with the appropriate actions that had been taken and evidence that the staff continued to monitor this. A second person's record showed that an occupational therapist had reviewed the person's health goals with them and their care worker. As a result they had given the person written exercises to strengthen their hands. Oral health care plans were in place and the outcomes of their dental appointments were documented. This demonstrated that the provider had identified and taken action to address the health conditions that affected people's health and wellbeing.

The provider was working within the principles of the Mental Capacity Act 2005 (MCA). The 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.

Care plans recorded the key aspects of people's care and demonstrated where they could make day to day decisions about the care they received. One person told us, "I make my own decisions, but was consulted about my care from the start."

Where people were living with their spouses their care plans indicated if they had power of attorney in relation to their health, welfare and/or finances. The provider used MCA assessment forms and best interests decision tools to regularly assess people's capacity in relation to day to day decisions they made. Information for one person showed that they refused to use equipment which helped to move and position them safely. This led to a best interests meeting being held in consultation with health professionals about the person's specific decision. Following this a plan of action was put in place to mitigate the risk and we found this was being followed and reviewed. For a second person, the provider had assessed a person's ability to retain information. Records showed that they could communicate effectively and that care workers should engage the person in meaningful conversations. This meant that the provider involved people in decisions and encouraged them to make choices to ensure that their rights were protected.

People's care records had been signed by people and/or their representatives to show that they had agreed to their care. The staff we spoke with gave us examples of how people consented to their care. Care workers were given information about the five key principles of the MCA as part of their induction to ensure that they understood their responsibilities.

Good

Is the service caring?

Our findings

People told us that the care workers who helped them were caring and knew them well. One person said, "They're very caring; they know me and my needs well." A person's relative said, "I think they're caring, they are very chatty and are concerned for [my family members] wellbeing."

One page profiles gave details about people's needs and what made them happy so they could continue to lead fulfilling lives. People told us that care workers spent time getting to know them and asked them about their interests and how they liked to spend their day. One person said, "Once caring duties are done, we have a chat and a cup of tea; we talk about families; we've become very good friends." Notes highlighted that staff took the time to talk about the positive aspects of the day with a person whilst they shared breakfast with their significant other. Another person's records showed that they liked their own company and valued their independence.

People were encouraged to make decisions about their care and whenever possible, these were accommodated. For one person, we found that their photograph was not held on their file because they had made the decision they did not want their photographic identification on their records. Other examples showed that a person had chosen to have their furniture rearranged and that staff had moved their bed so they could have a full view of the garden. We noted that some people's care had been sensitively planned and recorded, taking into account psychological and emotional support, reassurance and comfort they may need from staff.

People and their relatives were given the opportunity to share their experiences of care. The managing director had informed a person and their family member about a documentary they may wish to partake in organised by an external company. The documentary was about the experiences of people living with dementia and how their relatives cared for them. Notes showed the person had accepted and had taken part and their relative had thanked the provider for the opportunity and had invited them to the screening of the documentary when this was finished. This demonstrated that the provider promoted and encouraged person-centred activities for people to make them feel valued.

The provider aimed to provide continuity of staff with the right caring values. A care worker commented, "What I love is doing my bit for the community and doing the right thing for people. At some point I will need a carer in my life and I like to think about what that would be like."

The registered manager sought people's feedback during spot checks to review if they were treated with dignity and respect and people told us that their privacy and dignity was respected. One person commented, "The carer always respect me and treats me with dignity; and makes certain I'm covered up and protects my modesty." There were dignity champions and the staff told us how they understood how to provide care in a respectful way. They were given a pocket sized leaflet on the 10 ways to provide dignified care to people.

There were written compliments that demonstrated the praise that had been received for the care that was

provided. A person had written, 'I feel like I have made new friends and they make me feel more positive.'

Good

Is the service responsive?

Our findings

People had personalised care plans that outlined how they wished to be supported by the care workers who helped them in their homes. One person said, "The carer seems to know what [they] are doing when washing my hair and bathing. It comes naturally as they have been shown how to do it."

We checked the care and support plans and found that each person's records demonstrated that all of their needs were assessed by the provider before personal care was carried out. Care plans were reviewed when people's needs changed and staff told us they were kept informed when this was done.

Information showed that the registered manager worked jointly with health and social care professionals to look at ways to build people's confidence and manage behaviour that challenged. For example, the care records for a person living with dementia showed that discussions were held with care workers to show them how to establish boundaries with the person when they displayed behaviour that challenged. A behaviour chart was in place to help staff observe and record the person's behaviour weekly. Suggestions were also made by the provider that it would be helpful to write down daily routines to give the person a sense of security. This was reviewed frequently with the input of health professionals and was being continually monitored. For another person we saw details of how an unexplained health condition had impacted their life and relationships. They had visited a health professional who had offered advice but a solution had not been found. Records showed that the registered manager had taken the time to research the person's health need to see how they could further support them with their condition. This demonstrated that the provider was responsive to help improve people's wellbeing.

The hobbies and pastimes people enjoyed doing were noted in their care records. This comprised of the creative interests that they continued to pursue, such as drawing, and the television programmes people enjoyed watching, for example, natural history documentaries. Care plans gave guidance on how staff were required to encourage to them to maintain their hobbies and interests. Where one person enjoyed the arts and liked to listen to audio books the staff were asked to engage them in discussions about the author and their favourite subject matter.

The provider understood people's diverse needs and worked to deliver care and support that promoted equality. A care worker explained, "I would say that I have always worked in a non-discriminatory way. Some service users have different needs and we like to give them as much support as possible." The managing director showed us information to demonstrate they had run a marketing campaign to actively support people in the Lesbian, Gay, Bisexual and Transgender (LGBT) community. They told us they had advertised to specifically attract people from the LGBT community and that this was an area they were keen to expand and develop further. Staff were given training and provided with briefings on a wide range of specific subjects, such as modern day slavery, female genital mutilation (FGM) and the Jewish way of life. This helped to raise care worker's awareness of the importance of equality, diversity and human rights.

People and their relatives told us they understood the information given to them. One person said, "I understand all of it, I haven't lost my marbles yet" and a relative commented," The information is all in a

book. It's early stages yet, but they're beginning to understand what [my family member] prefers." Accessible information was provided for people to meet their communication needs, for example, we saw that information was provided in different languages, such as Cantonese so that people could understand the information available to them. Where people had requested care workers who spoke the same language as them, the provider had actively recruited care workers to meet their needs.

The provider was not currently supporting people at their end of life and they told us there were plans in place to facilitate end of life care training for staff.

People and their relatives said they knew how to raise a complaint and were confident the provider would act on these if they had cause for concern. A relative told us, "I know the manager and we speak often. I rarely need to phone her; she will always take my concerns on board, but I haven't had any concerns." People were given the complaints procedure when they started to use the service. Systems were in place for recording and managing complaints. Records showed there had been four complaints and these had been investigated and satisfactorily resolved.

Good

Is the service well-led?

Our findings

People and their relatives told us the service was well run. Their comments included, "It's very well run and the carers are good" and "Early days to say but it seems quite a flexible service." And a relative said, "A very efficient organisation and staff all get on well with each other. I would recommend this company to anybody; kind, friendly and not expensive." The Care Quality Commission (CQC) had received positive feedback from health and social care professionals in the Provider information Return (PIR) about their ability to run a good service.

There were effective systems in place to assess the quality of the service provided. We spoke with the compliance manager who explained how the service was governed by adopting the 'mums test'. They told us about the quality assurance tools that were used to improve the service. Audits were carried out on people's records and the how staff provided people with their care and support. Records showed that the provider had identified shortfalls and addressed this with staff to improve their work practice. For example, the provider had picked up that daily records did not show how people had achieved their daily outcomes and a demonstration of this was given to the care worker about how this should be done.

Preliminary surveys were sent to people to obtain their feedback and ideas on how the provider could improve how the service operated. These were in the process of being reviewed and finalised. Spot checks such as telephone calls and home visits had been undertaken and records showed that people had spoken positively about the provider and the care workers who supported them. The managing director showed us the reviews they have received from people on a homecare website and these demonstrated a good level of satisfaction.

The registered manager told us that they always encouraged a culture of openness and transparency with their staff team and the care workers we spoke with confirmed this. The provider displayed the CQC poster 'Tell us about good or bad care' in the office. This was so that care workers could share their experiences with the CQC about the quality of care people received. The registered manager and the managing director were knowledgeable about the adult social care sector. They understood people's needs and how they wished to be cared for and adopted a hands on approach to being involved at every stage to help deliver the right care for people. The registered manager told us they were looking at ways to raise the profile of care workers as they did not always get recognised for the hard work that they did and for this reason referred to care workers as 'care givers'. Staff spoke positively about the support and encouragement they received from the provider. They had access to up to date training and were given direction and support when this was needed.

The provider had good links with local community resources that reflected the needs and preferences of people who used the service. We saw that staff were provided with opportunities to offer additional support to other people in the local community who did not use the service. For example, care workers volunteered at local memory cafés and paid visits to people in the local community to help prevent social isolation.

We noted that the provider worked in partnership with other professionals to make sure people received

appropriate support to meet their needs. The registered manager told us about the key relationships she had maintained with other providers of healthcare and we saw records to evidence that this had helped to achieve the best possible outcomes for people. Information showed that the provider was actively involved in attending forums, lectures and partnership meetings to keep up to date with changing legislation in adult social care. For instance, the London care and support forum and a men's health lecture as part of the dementia action alliance were attended among others.

The provider spoke about their plans for the service that included producing a new hospital passport for the needs of people who used the service and plans to move from using paper based files to electronic recording. On the second day of our inspection we saw that an apprentice had been recruited and we observed them being inducted about how the service operated. The managing director told us they had recruited the apprentice specifically to raise the social media profile of the service.

The provider held memberships with a number of professional organisations. They received information and updates from a wide range of companies such as the Social Care Institute of Excellence (SCIE), Skills for Care, the National Institute for Health and Care Excellence (NICE) and the UK Home Care Association (UKHCA). This helped the provider to be kept informed of matters that were relevant to the people they provided care for.

People's confidential records were held and stored securely in locked cabinets to protect their data. Providers of health and social care are required by law to inform the CQC of significant events that happen in the service and we had been kept informed of these events when they had occurred.