

# BEN - Motor and Allied Trades Benevolent Fund Lynwood Home Care

## Inspection report

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Date of inspection visit:  
22 September 2016

Date of publication:  
18 October 2016

## 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

Lynwood Home Care provides personal care to older adults, some of whom have dementia, in Sunningdale, Berkshire. BEN is a not-for-profit organisation, dedicated to those who work, or have worked, in the automotive industry and their family dependents. The office is located in BEN's Lynwood Village; a very large purpose-built modern community, where the provider also operates a 96 bed care home with nursing. In addition, there is a café, restaurant, pub, hairdresser and health centre.

The village currently has 66 self-contained apartments and 10 cottages. The provider is currently building another 100 apartments due to open in about spring 2017. The service will increase in size as the village reached full occupancy. People who currently use the service currently live in the existing apartments.

Staff provide care to people within their own homes. Services provided range from assistance in the morning (including helping people get out of bed, to wash, get dressed and have breakfast) shopping, preparation of food, medication prompting and assistance with evening care routines. There is a continuum of care, as people who receive personal care and require residential or nursing care can then opt to move into the care home on site.

At the time of the inspection, there was no 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 service manager had applied to become the registered manager and the application was in progress with our registration team.

The service has not previously been inspected since registration. Therefore, this is the first inspection of the location under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and rating required by the Care Act 2014.

At the time of the inspection, 17 people used the service and there were 5 staff. People received calls in their apartments at set times throughout the day. The service also operated 24 hours a day, seven days a week and people, relatives, staff and healthcare professionals could telephone the office anytime to receive support. After hours, calls were diverted to the on-call manager's mobile telephone.

People were protected against abuse or neglect. People's and relatives' opinions of safe care were overall positive. There were sufficient staff to meet people's needs and the service appropriately determined correct staff deployment. Feedback from people and relatives indicated that staff were sometimes late to calls but people told us they were not concerned. When we checked, delays in calls were minimal. People's medicines were administered, stored and disposed of appropriately. The service needed to ensure that medicines administered were always signed for.

We found staff received induction, training, supervision and performance appraisals. The service utilised

Skills for Care's 'Care Certificate' for new carers and there was evidence. Recruitment and selection of new staff members was robust and ensured safety for people who used the service. Consent was gained before care was commenced and people's right to refuse care was respected by care workers. However there was a risk that consent may not always be gained lawfully by the service from the 'relevant person'.

Staff were kind and caring. People's comments showed they were satisfied with the care they received. We determined care workers respected people's privacy and dignity, and ensured people remained as independent as possible. People had regular opportunities to provide feedback to the service and also have a say in their care package.

The service was responsive to people's needs. People had the ability to share their compliments, concerns and complaints in an open and transparent manner. Where feedback was provided by people or relatives, management would undertake necessary investigations, make changes to their care package and report back to the person. People's care plans were not person-centred and needed to change from a task-led focus. The service manager showed evidence they had worked on this and transfer of care plans to a better format was underway.

All of the people we spoke with after the inspection expressed confusion about the management of the service. They were unsure who the manager was and wanted better information about the management of the service. We were unable to gauge staff opinion about the leadership of the service. However, the service manager explained to us their recognition of care workers' good performance. We found that the management conducted a small amount of checks to assess the standard of care.

## 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.

People were protected from abuse or neglect.

The service adequately assessed and mitigated risks.

The service deployed satisfactory numbers of staff.

The service managed people's medicines safely.

### Is the service effective?

Good ●

The service was effective.

There was effective staff training, supervisions and performance appraisals.

People's consent for care was obtained in accordance with the Mental Capacity Act 2005.

People were supported to maintain a healthy balanced diet.

People were supported to have access to healthcare services and receive ongoing support from community professionals.

### Is the service caring?

Good ●

The service was caring.

People were treated with kindness and compassion.

People had choice, independence and control of their personal care.

People's privacy and dignity was respected.

### Is the service responsive?

Good ●

The service was responsive.

The service listened to people's wishes and preferences.

People's care plans were not person-centred but the service was working to improve this.

Staff had good knowledge of the people they cared for.

There was a satisfactory complaints process and people knew the procedures for raising any concerns.

**Is the service well-led?**

**Good** ●

The service was well-led.

The service had clear objectives and values.

People could not accurately tell us about the management of the service.

The service gained registration in April 2015, therefore a small number of audits were in place to determine the quality of people's care.

# Lynwood Home Care

## 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.

The inspection was undertaken by one adult social care inspector, took place on 22 September 2016 and was announced. An Expert by Experience conducted telephone surveys with people and relatives after the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The provider was given 48 hours' notice because the location provided personal care in the community and we needed to be sure that staff and managers would be present in the office.

For this inspection we asked the provider to complete 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 reviewed information we already held about the service. This included statutory notifications we had received. A notification is information about important events which the service is required to send us by law. We also looked at feedback we received from members of the public leading up to the inspection.

At the inspection, we spoke with the service manager and service coordinator. After the inspection we also spoke with seven people who used the service and a relative. We did not visit people's homes as part of this inspection. We were unable to speak with care workers as part of this inspection. However, the service coordinator also performed personal care and was able to tell us about people who used the service.

We looked at eight sets of records related to people's individual care needs. These included support plans, risk assessments, medicines administration records (MARs) and daily care worker notes. We also looked at two staff personnel files and records associated with the management of the service, including quality audits.

# Is the service safe?

## Our findings

People we spoke with told us they felt safe when care workers supported them in their homes. When asked if they felt safe one person said, "Yes absolutely, why would I not feel safe?" Another person told us, "Yes. The carers are all professional." A third person we spoke with commented, "I do; the carers are very good. I would call the office [if I didn't feel safe]." A relative told us the care was safe but commented about the after-hours ability to contact the service. They told us, "Yes, there is an out of hours' number we can ring. But often the number isn't answered out of hours. If you left a message sometimes it was called back in a responsible time but sometimes it wasn't." The service manager told us that the service actively wanted to ensure people were free from harm.

The provider had appropriate policies for safeguarding and staff whistleblowing (reporting of unsafe work practices by staff), and these were up-to-date. The service's policies were in accordance with the Care Act 2014. The service had access to a copy of the Berkshire safeguarding adults procedures, which contained the necessary information about dealing with and reporting abuse or neglect. The service manager and service coordinator were clear about their part in managing safeguarding concerns. This showed the service was aware of procedures to protect people. Care worker inductions and training included safeguarding. Staff training about safeguarding vulnerable adults was robust, as there was the requirement to attend a half day course and annual updates to refresh their knowledge. The service reported safeguarding allegations to the local authority and us, in line with procedure and regulations. People were protected because Systems were in place to prevent abuse and neglect.

The service assessed and managed people's risks of personal care. We found care documents contained satisfactory risk assessments and management plans. We looked at care records for people who used the service. In the risk assessments and care plans we examined, we saw a comprehensive range of documents. Examples of risks recorded included environmental hazards in people's homes, moving and handling, falls, medicines administration and nutrition and hydration. People also had the ability to summon help via call bells in their apartments and pendants worn like a lanyard. These were responded to by a 24 hours on-site concierge. Where necessary, service management were called or medical help obtained. People could also telephone the concierge staff from their apartment for assistance.

Staff documented incidents or accidents to people when they occurred. We found there were six accident forms completed within the prior year of the inspection. We saw these reports were reviewed by the service manager. Where risks to people were identified in the report, necessary changes were made to their care. The service ensured that people were protected from risks associated with their care and documented when harm occurred.

Although people's individual risks were assessed and managed, the service did not have a business continuity plan in place at the time of the inspection. A business continuity plan is an essential part of any organisation's response planning. It sets out how the business will operate following an incident and how it expects to return to 'business as usual' in the quickest possible time afterwards. The service manager and service coordinator acknowledged this. At the inspection, we asked the service to submit a business

continuity plan without delay. The service manager submitted a comprehensive document that detailed what the service would do in the event of emergencies. We were then satisfied the service had the necessary plan in place in the event of emergency occurrences.

People's feedback after the inspection indicated that there was some dissatisfaction about timing and promptness of calls. One person said, "They can be late nothing more than 15 [minutes]. They stay longer when they are late to make up for it." Another person who used the service stated, "Yes, sometimes they can be late but it is very rare. I would call the office if it was a problem." A third person commented, "It depends on other people if they ask them to do other things. No they don't call me, but I am not worried." The service office was situated on the site of where people lived, and we found calls were never delayed by 15 minutes or missed.

The service was registered for just over one year, and the number of people who used the service was relatively small. At the time of the inspection, this was reflected in staff numbers as there were four staff that provided care. We found the service was in the process of a large recruitment drive to increase staffing numbers in order to offer more care packages to people. The service manager told us that staffing deployment was matched to people's needs. In the initial assessment before care packages commenced, people's dependency was determined to understand the number of staff required for calls. Where the person required hoisting because of their mobility, this was always completed with two care workers present. The provider had some flexibility in their workforce. Due to the unique setting, staff from the care home on site were trained and could provide personal care if there was a staff absence at the service. We found that the service deployed sufficient staff to ensure people's care needs were met.

We looked at two personnel files of care workers. We found personnel files contained all of the necessary information required by the regulations and no documents or checks were missing. We found this included criminal history checks via the Disclosure and Barring Service (DBS), checks of previous conduct in other roles, and proof of identification. The service recorded staff's right to work in the UK. The service ensured that satisfactory checks of applicants' prior work conduct were in place. Where necessary, the service obtained additional references to ensure that applicants were suitable for the role of care worker. People were protected because the service had strong recruitment and selection procedures.

People's medicines were safely managed. We were told that in people's homes, medicines were often pre-packed into blister packs by the dispensing pharmacy. Some people took medicines without assistance. Staff supported people to take medicines only if they required assistance or were unable themselves. Staff completed training in medicines safety. Staff training included both theory and practical demonstrations of medicines administration. We looked at two people's medicines administration records (MARs). We saw that on limited number of occasions, the care workers administered medicines but failed to sign. We brought this to the attention of the service manager. The service manager took immediate action to ensure this did not occur again.

## Is the service effective?

### Our findings

Four people we spoke with told us they felt that staff were trained appropriately to help with their personal care needs. The other three people were unable to answer our question. One comment was, "Yes, it always feels like they know the answer to every question I have and I never feel unsure about them." Another person told us, "They are not bad. I've not noticed anything to say they were unskilled."

The provider had a dedicated trainer for staff at the location. We saw new care workers received induction, support and a mentor to establish knowledge and skills to carry out their role. Care workers attended induction on site. After this, care workers shadowed another experienced care worker for at least four days of calls, depending on their prior experience working in adult social care. The service manager then conducted a competency check of the care worker to ensure they could effectively complete personal care. The service manager also completed an unannounced 'spot check' of the care worker to ascertain their effectiveness of providing people's care.

We found appropriate subjects related to being a care worker were covered during induction. The service used industry-wide training methods for adult social care staff, such as Skills for Care's 'Care Certificate'. New care workers were required to undertake the required 'Care Certificate' to ensure they were able to carry out their roles and responsibilities. The service recorded staff training in a database which showed the due date for it to be completed and the date it was completed. Staff completed ongoing training throughout their employment at the service. Topics included manual handling, infection control, health and safety and safeguarding vulnerable adults. We found staff had completed or were in the process of completing formal qualifications in health and social care. Staff received appropriate supervision sessions with the service manager or service coordinator. Staff were required to set objectives each year and have performance reviews. We found people received effective care because staff received appropriate training, supervisions and performance appraisals.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

At the time of the inspection, the service worked in line the requirements set by the MCA and the associated Codes of Practice. We found consent was always gained for people's care. We saw consent was obtained from people who had satisfactory mental capacity to make the decision themselves at the time. There was a risk however, that the service could ask relatives or 'next of kin' instead for agreement and signatures on consent forms. The service manager was not aware of whether any person who used the service had

appointed a deputy for finance or care via a power of attorney. We pointed out that the service must have a defined process of obtaining consent if a person lacked capacity to make the decision themselves. This included the need to check the 'relevant persons' legal authority to consent on behalf of others. Where there was no one who could legally consent for a person, the service did have a best interest decision-making process in place. The service manager and service coordinator understood the MCA and consent processes. They took immediate action to ensure that people's future consent was always in line with the MCA and Codes of Practice.

Some people who used the service received support with food shopping, eating and drinking and the preparation of their meals. Where necessary, the person was encouraged to be as independent as possible in heating, cooking and eating their meals. People's records contained assessment forms about eating and drinking. Where necessary, meal logs recorded what people had to eat and drink. We viewed examples of the meal logs and found these were appropriate. Staff called health professionals if people with health conditions did not consume sufficient food. This ensured the risk of malnutrition over time was mitigated for the person. We saw people's preferences for meals were recorded. In the location where people lived, there was a restaurant, coffee shop, and small food store.

We saw people were supported by the service to attend all necessary medical and healthcare appointments away from their own homes. Examples of good support to people related to healthcare included assistance with GP visits, dentists and opticians. In two people's care records, we observed that support from a physiotherapist was documented and that staff supported people to undertake exercises the health professional recommended.

# Is the service caring?

## Our findings

People we spoke with felt that care they received was kind. When we asked if staff were caring, one person said, "Yes, they are lovely, always trying the best to do everything I need. They are also very friendly and I can talk to them." A second person told us, "I think so. They are a nice group of people." We also asked why people thought the service's staff were caring. A person told us, "The way they talk to and look after you. The carers are magnificent." Another person said, "Yes, very caring, always there for you and helping out whenever they can." We saw there were a number of compliments on file since the service gained registration in April 2015. People were content with the professional bonds they shared with staff.

The service manager explained that the service actively asked people how they wanted things done in their care packages, and respected their choices. A 'start of service' questionnaire was completed with people before care commenced. We viewed three examples of this from people's care documentation. We saw this clearly defined what care people desired, times of calls and the way the care was planned to be provided. People we spoke with confirmed they were actively involved in making decisions about their care. One person said, "I think me and my daughters were all called in and we discussed exactly what I wanted. They went through a whole list of things." Another person told us, "We do have a chat as a family with someone from the office every now and again. They asked me about things I wanted to change and the things I like." A relative also agreed that people were involved in their care planning. They told us, "...Me and my sisters, we kind of instigated the whole thing. They just asked us and we told them. It was all what my [family member] wanted." The service manager confirmed that telephone surveys of people's needs were conducted by an independent third party every three months. This was to ensure people had an additional ability to say how they wanted their care altered. The service manager explained they received the feedback from the telephone surveys and could organise to speak with the person and discuss changes to their care package.

We did not visit people's homes as part of this inspection. However, we found that when personal care was provided, care workers ensured people's privacy and closed bedroom doors and curtains in people's homes. People's comments confirmed this. One person told us, "Yes [the care worker] always closes the door when I am having a shower, also closes my curtains when I am getting dressed in the bedroom." Another person we spoke with said, "...Never been an issue. I think they care about it more than I do." A third person stated, "Yes they do everything they can." We found staff had received training in privacy and dignity and this was embedded into the care they delivered to people. The service manager explained they intended to appoint a privacy and dignity staff 'champion' once the service grew larger. The staff member would then be a resource for other care workers and regularly check that people's privacy and dignity was protected.

Confidentiality in all formats such as paper-based and computer-based documents was maintained. People's confidential personal information was regularly removed from the care file in their apartment and placed into secure storage at the service's office. The service then scanned all paper documentation to electronic versions for storage and then shredded original documents. The service's office was locked when staff were not present and elsewhere at the location. At the time of the inspection, the provider was registered with the Information Commissioner's Office (ICO). The Data Protection Act 1998 requires every

organisation that processes personal information to register with the ICO unless they are exempt. We saw evidence of the ICO registration by checking the regulator's website.

## Is the service responsive?

### Our findings

The unique location of the service and where people lived meant that socialisation in the local community was easily available to them. The provider's care home had dedicated activity coordinators and scheduled a large amount of activities and events. The service encouraged people who received only personal care to attend and take part. Care workers from the Lynwood Home Care explained to people what events were on. The service also provided written information to people about activities. The service manager explained that people had participated in the activities on site, and expressed their enjoyment at being able to lead a fulfilled life. We were told one person had stated, "I was so excited about going to musicals and church activities." Some people preferred to stay in their home instead, and this choice was respected by the service and staff.

People who used the service confirmed they had verbally expressed their personal needs and preferences before care commenced and throughout continuation of their support. We looked at two people's care documentation to check whether care was responsive. We found that people were free to choose what aspects of care they needed assistance with, and the service encouraged people to remain as independent as possible. The service manager explained that at first visits, staff asked for information to ensure the person received a care package dedicated to them. When we looked at the care documentation, we found a 'personal profile' page. The document listed important information about the person. This included their social and family history, any communication difficulties and people's preferences or wishes.

However, the tools used for the care planning were unsatisfactory. When we looked at the risk assessments and care plans, we found them to be lacking details about the person as an individual. They consisted of brief information about activities of daily living. Activities of daily living (ADLs or ADL) is a term used in healthcare to refer to people's daily self-care activities. This type of care planning tool is not normally suitable for services that provide personal care in people's homes. We discussed this with the service manager. They agreed with our finding but explained they had already found this prior to our inspection. The service manager showed us the new care planning tool they had designed. The tool was different and focussed on staff detailing more specific information about the person, rather than task-based care. The tool also provided the service the ability to capture people's information that did not exist in the current care plans. The service manager explained that current care plans were being transferred to the new document and further input from people who used the service, relatives and health professionals would be sought. Additional information about the person would ensure that care planned was person-centred.

We recommend that the service implements and completes person-centred care planning within three months for people who use or intend to use the service.

People told us they knew how to make a complaint and would not hesitate to raise concerns. One person said, "I would complain to the lady downstairs, she's the second in command." Another person told us, "I would speak to the manager." When we asked people how they would make their complaint, one person said, "Call the office and speak to someone in charge." Other people we spoke with felt they would rely on their relatives or other parties to make a complaint on their behalf. For example, one person said, "I would

talk about it with my kids", and another person told us, "If it was something really bad I would talk to the council. Anything small I guess would be with the office." We were satisfied that people felt confident about making complaints.

The service listened to and learnt from people's experiences, concerns and complaints. The service user guide explained to people how they could provide feedback to the service. The complaints policy and procedure contained the information for various staff members regarding their role in acknowledging and managing complaints. The service manager was required to acknowledge complaints within three days after receipt and submit an outcome to the person as soon as possible. There was the ability to escalate complaints to the care director of the provider if people felt their complaint was not handled well by the service.

We checked relevant websites to see if members of the public had left reviews about the service, but there were no results. At the time of the inspection, the service had not completed any satisfaction surveys with people who used the service. The service had not invested in gaining people's feedback in a formal manner as a method of analysing performance. The service manager and care coordinator confirmed this was planned.

## Is the service well-led?

### Our findings

Our post-inspection telephone calls with people and a relative demonstrated confusion about the service's leadership. People told us that due to changes in management they were not clear about who the manager was. They were also unsure about the organisational structure. This feedback from the people we spoke with following the inspection indicated better communication about the service's management was needed. This would ensure people understood the different levels of management.

We were unable to speak with care workers as part of the inspection to gauge their feelings about the leadership of the service. This was due to the small workforce and their inability to be contacted. However, the service manager and care coordinator explained that they provided praise to care workers. Care workers who demonstrated they had provided good care were recognised and thanked by management. We heard examples of the recognition that the management had given to staff. No formal staff surveys were conducted since registration of the service. The service manager explained that the first staff survey was scheduled for October 2016. There were no formal staff meetings held or recorded, although daily 'catch ups' were held between the team members. Care workers at Lynwood Home Care were treated as part of the provider's bigger staffing group at the care home, and welcome to attend and join in planned events.

At the inspection, we reviewed the service's statement of purpose. A statement of purpose is a document required by regulations that must include a standard set of information about a service. The statement of purpose must include details such as the aims and objectives provided by the service. The statement of purpose was appropriate. The aim of the service was, "...striving to achieve high quality care in a safe family environment." The service's statement of purpose contained outdated information at the time of the inspection as it contained the previous registered manager's details. We asked the service to send an updated version following the inspection and this was received and reviewed.

Due to the type of service provided, there were a limited amount of times that the provider needed to legally notify us of certain events in the service. When we spoke with the service manager at the inspection, they were able to explain the circumstances under which they would send notifications to us. We checked our records for notifications the service had submitted to us. We found the service had complied with the regulatory requirements to notify us regarding the operation of the service.

A registered manager ('registered person') was not in post at the time of our inspection. This meant one condition of the provider's registration was not met. However, the service manager had applied to us on 28 July 2016 to become the 'registered person'. The service manager was due to have their 'fit person interview' with our registration inspector on 27 September 2016. A 'fit person interview' is used to assess the applicant's fitness to be registered in line with the regulations. In reviewing the application, we saw the service manager also applied to be the 'registered person' of the provider's care home. If successful at gaining registration, the service manager would be accountable for two locations.

We asked how the service manager would ensure Lynwood Home Care would be well-led. The service manager explained that a care coordinator was in place and responsible for the day-to-day operation of the

service. The care coordinator confirmed they could contact the service manager at any time and daily communication occurred about the service. In addition, the care coordinator attended meetings at 9am with the provider's other senior departmental managers. This allowed the provider's managerial team to raise any issues and ensure solutions were implemented, if needed. The service also employed a full-time administrator who managed office functions. In the Provider Information Return (PIR) we received prior to the inspection, the service manager detailed senior care workers would be employed as the number of people who used the service increased. This was reiterated at the inspection and we were satisfied that effective management was in place and already planned for the future expansion of the service.

Our inspection methodology meant a significant portion of our time was spent with the service manager and care coordinator asking questions and examining evidence. We found the management staff of the service were transparent, approachable and knowledgeable. We found the two staff displayed good insight and readily provided detailed information about the staff team, people who used the service, the service's strengths and areas for improvement. Therefore we found the service demonstrated good management and leadership.

There were a limited number of quality checks undertaken by the management to ensure good care. Care workers had random visits ('spot checks') by managers during care delivery, to ensure people's care was provided safely and effectively. We found the service checked daily notes from care workers when they returned to the office. Personnel file checks were conducted using a checklist before new care workers commenced at the service. This ensured that necessary documents were on file and prompted the administrator to follow up missing documentation.

Providers are required to comply with the duty of candour statutory requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to 'registered persons' when they are carrying on a regulated activity. The service manager was familiar with the requirements of the duty of candour and was able to clearly explain their legal obligations in the duty of candour process. The service did not yet have an occasion where the duty of candour requirements needed to be utilised. At the time of the inspection, the service had a satisfactory duty of candour policy.