Barmat Healthcare Limited

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Inspection report

Jhumat House
160 London Road
Barking
Essex
IG11 8BB

Tel: 02082141170
Website: www.barmathealthcare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an announced inspection of Barmat Healthcare Limited on 13 December 2017. This service is a domiciliary care agency. It provides personal care to older people living in their own houses and flats. At the time of the inspection, the service supported a limited number of people with personal care. This was the first inspection of the service since they registered with the Care Quality Commission (CQC).

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the legal requirements in the Health and Social Care Act 2008 and the associated regulations on how the service is managed.

Medicines were not being managed safely. Medicines as needed (PRN) had not been recorded accurately. A person had not been receiving a prescribed medicine. Staff had been trained in how to administer medicines safely. We found that medicine competency checks to ensure staff were able to safely administer medicines, were not carried out by the registered manager.

Spot checks had been carried out to observe staff performance to ensure people received the required care and support. However, the outcome and findings of the spot checks had not been recorded. The quality assurance system in place was not effective in identifying the shortfalls we found with medicines and record keeping during the inspection.

Risks had been identified and information had been included on how to mitigate risks to ensure people received safe care. Staff were aware of how to identify abuse and knew who to report abuse to, both within the organisation and outside the organisation. Pre-employment checks had been carried out to ensure staff were fit and suitable to provide care and support to people safely. Staff told us they had time to provide person centred care and had enough staff to support people. There were systems in place to reduce the risk and spread of infection. Staff had been trained on infection control and were provided with personal protection equipment to ensure risks of infection were minimised when supporting people.

Staff had received training required to perform their roles effectively. People were cared for by staff who felt supported. Staff had been trained on the Mental Capacity Act 2005 and knew the principles of the act. People's care and support needs were assessed regularly for effective outcomes. The service worked with health professionals if there were concerns about people's health. Staff could identify the signs people gave when they were not feeling well and knew how to raise any concerns.

People told us that staff were caring, they had a positive relationship with them and their privacy and dignity were respected. People were involved with making decisions about their care.

Care plans were person centred and detailed people's preferences, interests and support needs. People knew how to make complaints and staff were aware of how to manage complaints.

Staff told us the culture within the service was open and transparent and told us the service was well-led. People and staff were positive about the registered manager. People's feedback was sought from review meetings.

We identified breaches of regulation relating to medicines. You can see what action we have asked the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not being managed safely at all times.

Risks had been identified and information was included on how to mitigate risks when supporting people.

Staff were aware of safeguarding procedures and knew how to identify and report abuse.

Systems were in place to monitor staff attendance and punctuality.

Pre-employment checks had been carried out to ensure staff were of good character and suitable to care for people.

There were systems in place to reduce the risk and spread of infection.

Is the service effective?

Good

The service was effective.

People's needs and choices were being assessed to achieve effective outcomes.

Staff had received relevant training to care for people effectively.

Staff felt supported in their role.

Staff knew when people were unwell and who to report this to.

Is the service caring?

Good

The service was caring.

People had a positive relationship with staff.

People's privacy and dignity was respected.

People were involved with making decisions about the care and

support they received.

Is the service responsive?

Good

The service was responsive.

Care plans were person centred and included information on how to support people.

Staff had a good understanding of people's needs and preferences.

Staff knew how to manage complaints and people were confident about raising concerns if required.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Spot checks were being carried out to observe staff performance. However, records had not been kept of the findings and the areas that were covered.

Quality assurance systems were in place. However, the quality assurance systems did not identify the shortfalls we found with medicines and record keeping.

Staff told us the service was well-led and were positive about the management.

People's feedback was obtained through review meetings.

Barmat Healthcare Limited

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 carried out on 13 December 2017 by one inspector and was announced. We gave the provider notice as we wanted to ensure that someone would be available to support us with the inspection.

Before the inspection we reviewed relevant information that we had about the provider. We also received a provider information return (PIR) from the service. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we reviewed documents and records that related to people's care and the management of the service. We reviewed care plans, which included risk assessments and staff files, which included pre-employment checks. We looked at other documents held at the service such as medicine, training and quality assurance records. We also spoke to the registered manager.

After the inspection we spoke to one member of staff and one person who used the service.

Requires Improvement

Is the service safe?

Our findings

We found that people's medicines were not always being managed safely. We looked at Medicine Administration Records (MAR) for a person the service supported with medicines and found that these had not been completed appropriately. The service applied an anti-inflammatory medicine to reduce pain when needed (PRN). Medicines that are taken as needed such as painkillers and paracetamols are known as PRN medicines. We were informed that this had been applied but there were no records kept on the person's MAR of when the application was made, the reason the cream was administered and the effect this had on the person. This meant that staff may not be able to ascertain how many times the PRN had been administered to ensure the person only received an adequate amount throughout each day. This medicine was then prescribed to be administered three or four times a day from 27 November 2017. However, there were no records that showed the medicine had been administered from this date. We spoke to the staff member who supported the person, who had no knowledge that this cream had been prescribed to be administered daily and told us this was administered when needed only. After the inspection, the registered manager told us that this would be administered in accordance to the prescription and staff have been informed of this.

Staff confirmed that they were confident about managing medicines. A staff member told us, "I know what I am doing with medicines." Staff had been trained in medicine management. However, a competency assessment had not been carried out to check if staff were competent to manage medicines safely. After the inspection the registered manager assured us that competency assessments would be carried out.

The above issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

People told us they felt safe. They said, "Oh yes, I am" when asked if they felt safe around staff that supported them. Assessments were carried out with people to identify risks. Risk assessments that had been completed provided information and guidance for staff on how to keep people safe and were regularly reviewed and updated. There were risk assessments falls, moving and handling and environmental risks in people's homes. Risks had been identified and assessments included the risk and strategies to mitigate the risks.

A Waterlow chart had been completed for people at risk of skin complications. These charts are used to assess the level of risks with skin integrity. Where a person was at risk, a skin management plan was in place, which included monitoring the person's skin, drying their skin after a wash, encourage repositioning and reporting any red skin areas to the registered manager or a health professional.

Staff and the registered manager were aware of their responsibilities in relation to safeguarding people. Staff were able to explain what abuse is and who to report abuse to. They also understood how to whistle blow and knew they could report any concerns to other organisations such as the Care Quality Commission (CQC) and the police. One staff member told us, "There are many different types of abuse. There's financial abuse, where money goes missing. There is physical abuse, which means someone might get bruises and have

anxiety around someone. If this happens, I would report this to my manager. I can also report to you [CQC] or in severe cases to the police." Records showed that staff had been trained in safeguarding people.

We found that there were no recorded incidents or accidents. The registered manager told us that there had been no incidents or accidents since people started using the service. People and staff confirmed this. The registered manager and staff were aware on what to do if accidents or incidents occurred. There was a form in place that could be used to record them. In addition, the registered manager told us that if incidents or accidents were to occur, then this would be analysed and used to learn from lessons to ensure the risk of re-occurrence was minimised.

Pre-employment checks were carried out to ensure staff that were recruited were suitable to provide care and support to people safely. Staff confirmed that these checks had been carried out. We checked staff files which showed that relevant pre-employment checks such as criminal record checks, references and proof of identity had been carried out as part of the recruitment process.

Staff had no concerns with staffing levels. They told us that they were not rushed when carrying out their duties and had time to provide person centred care and support to people when needed. People did not raise concerns with missed visits or punctuality. A person told us, "Yes, always" when we asked if staff came on time and stayed the allocated time. A staff member told us, "Yes, I am always on time. If I am late, I will let [person] know." During the inspection, records showed that staff had to complete attendance logs evidencing the time they arrived and left. The logs were then reviewed by the registered manager to keep track of staff attendance and punctuality. Rotas were sent to staff a week in advance so that staff would be aware of who they would be supporting.

There were systems in place to reduce the risk and spread of infection. Staff had been trained on infection control. We asked the staff member we spoke with on how they minimised the risk of infection and cross contamination. They told us they were supplied with personal protective equipment (PPE) such as gloves, aprons and sanitisers when supporting a person. Staff told us they disposed of PPE in a separate bag when completing personal care. They also washed their hands thoroughly. Guidance was provided to staff on how to reduce the spread of infections. For example, on one care plan, information stated that before providing specific support, staff should wash their hands with soaps and use non sterile gloves.

Good

Is the service effective?

Our findings

People told us staff were skilled, knowledgeable and able to provide care and support. The person told us, "Yes, absolutely" when we asked if staff looked after them well.

A staff member told us, "I did a shadow shift before starting and also got to meet and greet the person I would be supporting." Records showed that staff had received an induction. The induction involved looking at care plans and shadowing experienced members of staff. Records showed that staff received introductory training that was required for them to perform their roles effectively and in accordance with the Care Certificate standards. The Care Certificate is a set of standards that health and social care workers stick to in their daily working life. The training included first aid, fire safety, food hygiene, moving and handling and health and safety. Staff had also received specific training in epilepsy.

Records showed that supervisions had been carried out and records of this were held in brief on the registered manager's diary. Records showed that only training was discussed with staff. There were no forms in place to record supervisions and the specific areas discussed such as performance, time keeping and standards of care being provided in accordance to the provider's supervision policy of areas that would need to be covered during supervisions. The registered manager acknowledged this and told us that a supervisions form would be put in place to record all supervisions. After the inspection the registered manager sent us evidence to demonstrate a supervision template had been created and told us this would be used to hold supervisions. Staff told us that they were supported in their role. A staff member told us, "[Registered manager] is pretty good. If I need anything, it gets sorted."

Pre-assessments had been completed prior to people receiving support and care from the service. These enabled the service to identify people's daily living activities and the support that they required, which allowed the service to determine if they could support people effectively. Using this information, care plans were developed. The service assessed people's needs and choices through regular reviews. Records showed that at the time of our inspection, there were no changes to people's needs. The registered manager told us if there were any changes, the care plans would be updated and these changes would be communicated to staff. This meant that people's needs and choices were being assessed to achieve effective outcomes.

We checked if the provider followed 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.

Staff had been trained on MCA and were able to tell us the principles of the MCA and the best interest decision process. A staff member told us, "If someone has a particular condition such as dementia, they may not have the capability to make some decisions. Person would then be assessed, their family would be informed and a decision would be made on their best interest." The principles of the MCA were displayed on the registered manager's office. The registered manager informed us that an MCA assessment had been

booked for a person they supported but the person refused this. Records confirmed this. The registered manager and staff informed us that the person had capacity to consent to care and treatment. A consent to care and treatment form had been signed by people providing consent for the service to support them. Staff asked people for consent before doing anything. A staff member told us, "Out of respect, I would not just do things before asking."

The registered manager told us that the service only provided limited support with meals. The support mainly included reheating meals already prepared. A staff member told us, "They [people] pick and choose what they want." There was information on people's care plans about people's likes, food allergies, to always ask people what they would prefer to eat and the times people preferred to have their meals. One person's care plan included that their fluid intake be monitored to prevent the risk of dehydration. Records showed that a fluid intake chart had been created and this was being completed during each care visit to ensure the person was given sufficient amount of fluid during care visits.

People's GP details and any community professionals involved in their care had been recorded in their care plans. Records showed that the registered manager had worked with district nurses to support people when needed. Staff had awareness of when people did not feel well and who to report this to. This meant that people were being supported to ensure they were in the best of health.

Good

Is the service caring?

Our findings

People told us that staff were caring. They told us, "Yes, very much so" when we asked if staff were caring.

People received care from staff who were familiar with their care and support needs. They confirmed they had the same staff supporting them when required. This helped with consistency and enabled people to have a positive relationship with care staff. A staff member told us, "I just chatted [with people] and got to know [people]. This helped with building confidence." A person told us, "Yes, I do like him [staff member]."

People had been included in making decisions about how best to support them. The registered manager was aware of how to access advocacy services to enable people to have a voice and to ensure their human rights were protected, if needed. Care plans had been signed by people to evidence they agreed with the contents of the care and support they received from the service. The person we spoke to told us that they had been included with the decisions made to receive care and support. Care plans reflected people's support needs. Independence was encouraged and records showed that staff should encourage people to support themselves. Staff told us they supported people to make choices in their day-to-day lives with personal hygiene and care. The staff member we spoke to told us, "[Person] does not want to give up [person's] independence so I would support them with this and just help them when [person] may struggle with something."

Staff ensured people's privacy and dignity were respected. The person we spoke with confirmed that their privacy and dignity was respected. Records showed that staff had been trained in privacy & dignity. Staff told us that when providing particular support or treatment, it was done in private and that they would always knock on people's door before entering. A staff member told us, "When I am doing personal care, I make sure [person] is covered" and "Before I go in the door is always ajar, but I would knock before going in."

Staff gave us examples of how they maintained people's dignity and privacy not just in relation to personal care but also in relation to sharing personal information. Staff understood that personal information should not be shared with others and that maintaining people's privacy when giving personal care was vital in protecting their dignity. We saw that confidential information such as people's care plans and medicines records were stored securely in the office.

People were protected from discrimination. Staff had been trained in equality and diversity. A staff member told us, "I treat people the way I would like to be treated. We are there for them." Staff understood that racism, homophobia, transphobia or ageism were forms of abuse. They told us people should not be discriminated against because of their race, gender, age and sexual status and all people were treated equally. People's religious beliefs were recorded on their care plan. People confirmed that they were treated equally and had no concerns about the way staff approached them.

Good

Is the service responsive?

Our findings

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a personalised service. People told us that staff were responsive. They said, "Oh yes, he [staff member] knows me well."

Each person had an individual care plan, which contained information about the support they needed from staff. People were asked if they preferred male or female carers. The staff member we spoke with told us, "The care plans are helpful." There was a personal profile, which included people's date of birth, religion, the date they started receiving support from the service, marital status and ethnicity. Care plans detailed the support people would require to ensure people received person centred care. There was a daily checklist on the care plans detailing the tasks that would need to be carried out during care visit. Care plans were individualised and included details of people's family members and details of health and social care professionals. In one person's care plan, information included that staff should clean person's spectacles in bathroom and put it on person to reduce the risk of poor visibility and to avoid leaving them in the bathroom. These plans provided staff with information so they could respond to people positively and in accordance with their needs.

There were daily records, which recorded information about people's daily routines and the support provided by staff. The staff member told us that the information was used to communicate with other external staff that supported people between shifts on the overall care people received. This meant that staff could summarise the care needs of the people on each shift and respond to any changing or immediate needs.

Organisations that provide NHS or adult social care must follow the Accessible Information Standard (AIS) by law. The aim of the AIS is to make sure that people that receive care have information made available to them that they can access and understand. The information will tell them how to keep themselves safe and how to report any issues of concern or raise a complaint. Care plans included how people communicated and how to communicate information. For one person, information included that staff should speak clearly and slowly in front of person as although person had a hearing aid, the person did not like to use this. Staff we spoke to did not know what AIS was in full but told us they looked at people's care plans on how to communicate with people and how to make information accessible. Care plan for one person also included staff should ensure the person wore their spectacle should information be made accessible to them. The person we spoke to had no concerns on how staff communicated with them.

Records showed that no formal complaints had been received by the service. The person we spoke with told us they had no concerns but knew how to make complaints and were confident this would be addressed. There was a complaints policy and procedure in place. Staff had received training about managing complaints. The registered manager and staff were aware of how to manage complaints. A staff member told us, "I would listen to their complaint and log it. Then I would report this to the manager."

Requires Improvement

Is the service well-led?

Our findings

We were informed that quality assurance systems were in place. However, there was no evidence that this was taking place as there were no records on audits that had been carried out and if any issues had been identified. We were informed that audits had been carried out on medicines management but the findings of the audits and the areas covered had not been recorded. We could not evidence that the medicines audits identified the shortfalls we found with medicines in relation to recording PRN administration and administering prescribed medicines. This meant that the quality assurance processes were not robust enough to identify shortfalls. The registered manager told us that quality assurance systems would be made more robust and sent us evidence after the inspection of audit templates which included area's that would be covered during audits. These included medicine and care plan audit templates.

The registered manager carried out spot checks on staff and told us she provided feedback to staff on the outcome of these checks but the findings and areas the spot checks covered had not been recorded in full. Supervision meetings had not been recorded in full. The provider's supervision policy stated, 'Each formal instance of supervision will be recorded using the forms attached to this policy. Employees should sign to agree the record is accurate and may retain a copy for their own information.' Records showed that forms had not been used to carry out supervisions. The supervision policy also included health and safety, rotas, time keeping and standards of working were to be discussed. Records showed aside from discussing training needs, these areas had not been recorded as being discussed. This meant that the registered provider had not maintained securely an accurate, complete and contemporaneous record to ensure there was always oversight on staff performance.

Staff told us that they enjoyed working for the service. A staff member told us, "Yeah, I like working here. They are pretty good. No issues." Staff told us that they were supported in their role, the service was well-led and there was an open culture, where they could raise concerns and felt this would be addressed promptly. A staff member told us, "[Registered manager] is pretty good. She is approachable and any issues I have, she deals with it." People were positive about the registered manager and the service. They told us, "Yes, very much so" when we asked if they were happy with the management of the service.

We have not received notifications and safeguarding concerns have not been raised with the Care Quality Commission (CQC), as no incidents which required a notification had taken place. A notification is information about important events which the provider is required to tell us about by law. The registered manager was aware of their regulatory responsibilities and knew about notifications and when to send notifications such as on safeguarding, serious injuries or incidents to the CQC.

People's feedback was sought through review meetings. Records showed review meetings had been held regularly and this included obtaining people's feedback. The registered manager told us as the service supported a limited number of people, surveys had not been sent yet. A questionnaire had been devised that listed questions around the CQC key lines of enquires, Safe, Effective, Caring, Responsive and Well-Led. We were informed that surveys would be used in the future to obtain people's feedback on the service. This meant that people's views were sought to make improvements to the quality of the care and support they

received.

Staff meetings were held regularly. The meetings kept staff updated about any changes in the service and allowed them to discuss any issues. Minutes showed staff held discussions on winter contingency plans, care updates and service improvements. This meant that staff were able to share information as a team and on ways to improve the service to ensure people always received appropriate support and care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider was not providing care in a safe way as they were not doing all that was reasonably practicable to ensure the safe management of medicines. Regulation 12(1)(2)(g)