

Givecare

Bosworth Homecare

Inspection report

Unit 7a Woodhouse Business Centre
Woodhouse Street, Woodville
Swadlincote
Derbyshire
DE11 8ED

Tel: 01283807867

Website: www.givecare.co.uk

Date of inspection visit:

09 May 2018

14 May 2018

Date of publication:

16 July 2018

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

Bosworth Homecare is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults and younger adults in Swadlincote and surrounding areas. Not everyone using this service receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of our inspection 79 people were receiving a service.

The service had a registered manager in place at the time of our inspection. 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.

At our last inspection in March 2017, we rated the service as requires improvement. This was because where people did not have the capacity to make some decisions and assessments were not carried out to ensure decisions had been made in people's best interest. Quality monitoring systems were in place but these were not always effective and had not identified that people may not have received their support visits at the agreed time. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the service provided to at least good.

At this inspection, we saw further improvements were still required. This was because there was insufficient staff to provide them with safe, effective dignified care from staff who knew them. Medicines were not always managed safely and safeguarding concerns were not suitably reported to protect people from potential future harm. People did not always receive their care at the right time and for the right length of time. Information was not always available in an accessible format. The quality monitoring systems were not always effective and had not ensured that improvements were made. This is the third consecutive time the service has been rated 'Requires Improvement'.

Providers should be aiming to achieve and sustain a rating of 'Good' or 'Outstanding'. Good care is the minimum that people receiving services should expect and deserve to receive and we found systems in place to ensure improvements were made and sustained were not effective.

Risks to people's health and wellbeing were assessed and this was reviewed to ensure people continued to be assisted in a safe manner. There were safe recruitment procedures in place to ensure new staff were suitable to work with people and staff understood how to reduce the risk of infection.

Staff were supported and trained to ensure that they had the skills to support people effectively. When people required assistance to eat and drink, the provider ensured that this was planned to meet their preferences and assessed need. People were able to make decisions about how they wanted to receive

support to ensure their health needs were met.

The support people received was reviewed to ensure it continued to meet people's wishes. People felt able to raise concerns or suggestions in relation to the quality of care.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Registration Regulations 2009. You can see what action we told the provider to take at the back of the full version of the 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?

The service was not always safe.

People felt there was not enough staff to provide safe and effective care. Where safeguarding concerns were identified, these were not suitably reported to ensure people were safe from potential future harm. Medicines were not always managed safely to ensure people received their medicines as prescribed. Risk assessments were completed and staff were suitably recruited into the service. Staff were aware of how to reduce the risk of infection.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Improvements were needed to ensure people's capacity was assessed to ensure that decisions were only made in people's best interests where they lacked capacity. People were supported to prepare meals and received the support they needed to keep well from health care services. Staff had the opportunity to develop the skills and knowledge they needed to meet people's care and support needs.

Requires Improvement ●

Is the service caring?

The service was not always caring.

People felt improvements were needed to ensure they were cared for by people who knew them well and understood how they wanted to be supported. Staff were respectful and people received care that respected their privacy. People were able to make choices about their care.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

People did not always receive information in an accessible format to help them to read and understand all information about the service. People had a support plan which included information about how they wanted to receive their care; this

Requires Improvement ●

was reviewed to reflect any changes. People knew how to raise concerns about the service and these were responded to.

Is the service well-led?

The service was not always well-led.

People did not always receive positive outcomes and improvements had not been made in the overall quality of service provision. Quality monitoring systems were not always effective to drive improvements. The ratings for the service had not been suitably displayed on the web site to inform people about the quality of the service.

Requires Improvement ●

Bosworth Homecare

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.

Bosworth Homecare is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults and younger adults in Swadlincote and surrounding areas. Not everyone using this service receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of our inspection 79 people were receiving a service.

The provider was given four days' notice to ensure people could consent to a home visit from an inspector. The inspection site visit activity started on 9 May 2018 and ended on 21 May 2018. It included telephone calls to eight people and six relatives; we visited five people who were accompanied by two relatives. We also spoke with five care staff, the training manager, the compliance officer and compliance manager, the operational manager, and the registered manager. We received information from the local safeguarding team and commissioners of the service. We visited the office location on 14 May 2018 to see the registered manager and to review care records and policies and procedures in relation to people's care. The inspection was also informed by feedback from questionnaires completed by 14 people using services. One inspector carried out this inspection with the support of an expert by experience who made telephone calls to people who used the service. An expert by experience is a person who has knowledge and experience of using care services.

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.

We looked at six people's care records to see if these were accurate and up to date. We looked at records relating to the management of the service including quality checks.

Is the service safe?

Our findings

At our last inspection we reported that people felt there were insufficient staff; the provider had recognised this and was recruiting more staff to meet people's support needs. At this inspection, we found that people felt more staff were still needed. The registered manager confirmed that they were continuing to recruit for new staff as a number of staff had left the service. Two people told us that they had calls that had been missed and family members had to contact the office to determine whether they would receive a call. Records confirmed there had been six missed calls this year which may have placed people at risk of harm as they did not receive their support visit. Other people received support from staff who they did not know. One member of staff told us, "We have to cover other people's rotas as they have left and not been replaced yet."

People were concerned that they no longer received information about their care visits and calls were missed or late. One person told us, "You never know who is going to turn up and when." Another person told us, "You can feel quite vulnerable and it's good to know who is coming. At the moment it could be anyone and you don't always know them." One member of staff told us, "We are having to rush around and leave early because the rotas aren't right. We were having more regular calls but now we can be sent anywhere and we have to leave early to get there." Another member of staff told us, "The rotas can come out quite late. People aren't happy because they don't get a rota at the moment so they don't know who will be coming."

This evidence demonstrates a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from harm as systems to ensure that safeguarding alerts were responded to, were not in place. Staff received training for safeguarding which covered different forms of abuse and how to make alerts if they were concerned. However, some people disclosed concerns to us that had not been reported to the Derbyshire County Council safeguarding team in line with the local authority safeguarding policy. One member of staff told us, "I'd call the office or the manager and let them know what had happened. They would let the safeguarding team know." Another member of staff told us, "We looked at how we would report something on our training. We were told we can report things directly but I would report this to the office first and it would be reported by the manager." We found that where potential safeguarding concerns had been raised with the registered manager, these had not been reported in line with the agreed policy. On one occasion, the registered manager had conducted their own investigation; the other occasion had been reported to the care manager within the local authority without primarily contacting the safeguarding authority. This meant that suitable systems were not in place to ensure that safeguarding concerns were investigated to ensure that people were protected from potential future harm.

This evidence demonstrates a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe systems to ensure people received their medicines as prescribed were not in place for all people. We saw, for one person the medicine administration records (MAR) had been hand written by a member of staff and this had not been checked by another person to ensure the accuracy of the information. The number of

medicines received into the person's home and not been recorded and there was no information about when the boxes had been opened. We saw there were gaps on the record, so it was not clear whether the medicines had been administered and we were unable to check this as the records were incomplete. The MARs were audited at the end of each month but there was no system in place to complete this alongside an audit of medicines that remained in the home. On one occasion, the person informed us they had been asked to take the medicines themselves as there were no staff available to complete the call. However, the staff came later that day and signed they had administered the medicines but it was not possible to determine whether they had received their tablets twice. The person needed eye drops to be administered and until the staff had received training, a family member administered these. We saw on the MAR that on some days the staff had administered these which indicated they may have received these on two occasions. The last review stated family continued to have responsibility and therefore should not have been administered by staff. To ensure the person was safe, during our inspection, the registered manager completed an investigation and reviewed their medicines to ensure safe systems were in place. Most people received their medicines in blister packs which were accompanied by a MAR. We saw where this system was used, medicines had been given as prescribed and there was a record that staff had administered these medicines.

We recommend that the provider considers current best practice guidance for managing medicines for people receiving social care in the community and take action to update their policy and practice accordingly.

Risks associated with people's care and support was recognised and managed. Staff knew people well and where people used equipment to move around their home, this was included in the assessment of risk. One person told us, "I feel quite comfortable with the staff. Nobody likes to use the equipment, but they make it as comfortable as they could and are always checking I'm alright."

Environmental risk assessments were completed which identified any hazards or obstacles inside or outside of the home; whether any equipment which was used was safe and where utilities could be turned off in the case of any emergency. People told us the staff left their home tidy and made sure any equipment used was stored away and did not obstruct any area. Staff had access to protective clothing to use to help to prevent the spread of infection. One member of staff told us, "There's always a stock of gloves and aprons in the office; we just have to come along and pick some up."

When new staff started working in the service, recruitment checks were in place to ensure they were suitable to work with people. We saw that staff's suitability for the role was checked by obtaining references, having a police check and confirming the validity of their qualifications, previous experience and training. Where staff had applied for police checks on line they could apply to have these renewed annually for a small fee and these were checked by the provider.

Is the service effective?

Our findings

On our last inspection we found that where people did not have capacity to make certain decisions, it was not clear how these decisions had been made and whether other people had the necessary authorisations to make decisions on behalf of others. This meant there was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On this inspection we saw improvements had been made, however further improvements were still required.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. People told us they felt they were not restricted in their care and staff supported them to make decisions about what they wanted. Where staff felt they did not have capacity to make particular decisions, new capacity assessments had been developed and completed with people. However, the assessments did not include information about how they had reached the decision about whether people lacked capacity. We also saw the assessments covered different decisions, for example, whether they had capacity to consent to personal care, needed support with medication and for moving and handling. The registered manager accepted that further improvements were needed to ensure it was clear how these were time and decision specific and demonstrated how these decisions had been reached.

We recommend that the provider seeks advice; training and guidance from a reputable source, to assess capacity and ensure decisions are made in people's best interests.

New staff received an induction into the service. When new staff started they worked with other experienced staff and had an opportunity to get to know people. People felt that staff had the skills to support them. Staff completed nationally recognised vocational training and the care certificate; this sets out common induction standards for social care staff. It has been introduced to help new care workers develop and demonstrate key skills, knowledge, values and behaviours which should enable them to provide people with safe, effective, compassionate and high quality care. One member of staff told us, "I enjoyed the induction. I have worked in this job before but I felt that the information was clear and I learnt about how to help people to move safely and how I needed to look after myself. If there was anything I didn't understand, they spent time with me to make sure I was confident. I felt I had enough information so I could help people." Where further learning was identified, the registered manager had arranged for staff to receive refresher training. For example, staff had received additional moving and handling training to ensure they used different equipment safely and knew how to identify risks. This meant staff were given opportunities to update their skills and knowledge to support people safely.

Staff were provided with support through individual supervision and checks were made in people's homes to ensure the staff were working safely. Where any concerns were noted on these visits, they were addressed through the supervision process and staff were encouraged to reflect on their practices and how they supported people to improve people's experience of care.

People were supported with their health care when needed. One person told us, "When I've been ill, the staff have stayed with me and telephoned the doctor; it helps when the staff know me as they notice if I'm not feeling myself and make sure I get an appointment." The staff told us how they worked closely with other health professionals to help to manage people's health and one member of staff said, "Some people are seen by a district nurse and we make sure everything is in their plan so we know what they want us to do. We have all their details, so if there is anything we need to report we can contact them." Any changes in people's health care was recorded in the support plan.

People were supported to prepare and eat their meals. Food, drinks and snacks were left available for people, so they had access to these between support visits. One person told us, "The staff leave everything for me on the table next to my chair. I've no need to get up for anything as it's all right next to me." Another person told us, "My family make sure I have all the meals I want and the staff ask me what I want to have. They are very good and if I'm running short of anything they let me know so I can tell my family or they will get it for me if I need it that day. I have no complaints." One relative said, "I leave meals which the staff give to my relative. They will always let me know if they haven't eaten much or what went down well." The support plan included information about how people wanted to be supported with their diet to ensure staff knew and understood their preferences.

Is the service caring?

Our findings

People had mixed views about how they were supported and people's views about how well the service was staffed had an impact on their views. Where people had different staff visiting who they had not been introduced to, they felt that care could be improved. They told us that staff did not always know how they preferred to have their care delivered and they felt uncomfortable when receiving personal care. One person told us, "They have training, but if it's new staff, they just don't know you." Another person told us, "It makes you feel uncomfortable. You don't want intimate care from people you don't know; it can be embarrassing." Another person told us, "Nobody wants a stranger to give them a bath, they are not even introduced to us. I don't always have a rota so they could be anybody. They do wear their ID badge and have a uniform on but this is my home and it doesn't seem right that anyone can just come in. I'm sure they do their best, it's the way it's organised."

Where people had their care and support from staff who they knew well, they considered the care to be good and welcomed having care from staff they trusted and told us they were treated with kindness and respect. One person told us, "I feel very safe, they're all very good, there's no one who I don't get on with." Another person told us, "All the staff are lovely but it makes a difference if you know them and trust them. When the staff I know visit, they know what they need to do and do it the way I like it. I trust them. If it's someone who is a relative stranger, I have to tell them all the time what I want and I feel quite uncomfortable when they are doing my personal care."

We saw that people's preferences for care had been recorded; for example, how they preferred their personal care. Where personal care was delivered, people told us the staff took time to ensure they were covered to respect their privacy. The provider was committed to supporting staff to become a dignity champion and staff were being offered training to carry out this role. A dignity champion is someone who ensures that being treated with dignity is a basic human right. They believe that care services must be compassionate, person centred, as well as efficient, and are willing to try to do something to achieve this. Staff explained that this training looked at the core principles of dignity, how dignity could be compromised and care practices such as making sure staff closed people's curtains and closed doors.

People were involved with the planning of their own care and told us that they were listened to. Staff understood the importance of treating people with respect and did not discriminate based on people's protected characteristics and people were respected. People were able to choose the gender of staff who supported them. One person told us, "I made it quite clear that I only wanted female staff to provide my care and they have respected this decision. I wouldn't be comfortable with a man doing this; it's just my preference."

People were encouraged to maintain their independence when possible. One person told us, "I do as much as I can for myself and the staff don't interfere. It's hard for me to reach down and wash my legs or put cream on so I do everything else but that." Another person told us, "I'd love to do more for myself but I can't. Some days are better than others and the staff that know me, know that I do what I can for myself and staff always ask me if I'm comfortable and give me that extra time."

People were supported to maintain relationships with family and friends and staff recognised people's rights to have and maintain personal relationships. One person told us, "The staff are very friendly. It must be hard as they come into our home for me but they never ignore the rest of the family. If making a drink for me they will ask if they want one too. It may only be a little thing but it helps to make us feel comfortable and it's lovely that they are interested in us all."

Is the service responsive?

Our findings

Information was not always provided in an accessible format. As part of the quality assurance survey some people requested the service user guide in large print. However, the registered manager had not used this information to develop other information, such as the complaints procedure or their support plan in large print to ensure that all information they needed was in an accessible format. Following this feedback the registered manager and staff team decided that where large print was needed, they would ensure their file was labelled to clearly identify this and all documentation would be reprinted in a more suitable format.

People had a support plan developed following an assessment of their needs. People felt this reflected how they wanted to be supported and one person told us, "The staff came out and spoke to me about what I wanted. I have a folder here with everything written down." Staff felt the care records were easy to use and provided them with the information they needed when visiting people. One member of staff told us, "In an ideal world we would have an opportunity to meet everyone before we visited them. When we don't know them, we can come into the office to read their file or read it at the start of the visit. It gives a good picture of what we need to do. We always ask people too to make sure they are happy with what we are doing." The support plans included information about how people wanted to receive care, important people and any advance decisions they may have about future care.

Daily records were completed which detailed the support people received. Information included the food and drinks they had provided for the person to ensure this could be monitored between visits where needed. One member of staff told us this information was valuable as they always read the previous notes so they could check for any changes and the care that had been provided.

People's care was kept under review to ensure it reflected their preferences and any changes they wanted. People told us that the staff visited them to see if they were happy with their care and if any changes were needed. One person told us, "I've had everything reviewed and the staff went through everything. My family can come and get involved which is helpful as sometimes I forget things." Staff told us that should the plan change, they were kept informed of any changes by telephone to ensure they had the information they needed to meet people's changing needs.

People were encouraged to share their experiences and raise any concerns. People were given information about complaints and where they had made a complaint, this was investigated and there was a record of it and people were informed of the outcome. The registered manager recorded and monitored any complaints received within their procedure.

People were supported to pursue activities and interests that were important to them. The provider arranged services for people to be supported with their interests or to support people when out, for example when shopping. During these support visits, personal care was not provided and therefore this support is not regulated by us.

At the time of our inspection there was no one receiving end of life care and so we did not review this.

Is the service well-led?

Our findings

On our last two inspections we found that improvements were needed with how people were supported to make decisions and to ensure that there were sufficient staff to provide an effective service for people. On this inspection we found further improvements were still needed. We also found that medicines management needed to improve to ensure people receive their medicines at the right time and safeguarding concerns had not been reported. We have reported this concern in the 'safe' domain.

The overall rating for this service is requires Improvement. Providers should be aiming to achieve and sustain a rating of 'Good' or 'Outstanding'. Good care is the minimum that people receiving services should expect and deserve to receive. The service has been rated as 'Requires Improvement' on three consecutive inspections. This shows that effective systems were not in place to ensure the quality of care was regularly assessed, monitored and improved.

This was a breach of Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the systems to monitor and assess the service to drive improvements were not effective and lessons had not been learnt. Improvements had not been made to ensure that people received their call at the time that was expected or to stay for the correct length of time. We saw there were occasions that staff had not logged out of a call via the telephone; staff within the office had manually recorded the leaving time but we found that calls over-lapped, meaning that staff were wrongly recorded to be with two different people at the same time. We saw on daily record sheets that there were occasions where different times were recorded to the times the staff actually arrived and left people. Monitoring systems did not include processes to check that staff recorded the time they actually spent with people. Systems were also not in place to identify whether people received their support call as had been commissioned. These concerns had been identified as part of the wider monitoring systems carried out by the provider. However, improvements had not been made. We have shared this information with Derbyshire local authority.

This evidence demonstrates a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and on their website where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their report and rating in the office. However, the website referred to a report carried out at a different branch in 2016 where the service was rated as Good overall. The judgement of our last inspection was Requires Improvement and this was not displayed. Following our inspection the provider made arrangements to add this report onto their website through the 'Contact us' heading. However, the report for the main office rated as Good, remained on the home page and it was not clear where to access our report to ensure people could clearly be informed about our judgement of Requires Improvement at this service.

This evidence demonstrates a breach of Regulation 20(A) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a registered manager and people who used the service knew who they were. We received notifications from them about important events so that we could check that appropriate action had been taken. However, we were not always notified of all events as the registered manager had not identified where potential safeguarding concerns needed to be reported. As part of the safeguarding training, staff received guidance on how to raise concerns about risks to people and poor practice in the service and knew about the whistleblowing procedure. Whistle blowing is where staff are able to raise concerns about poor practice and are protected in law from harassment and bullying. However, we saw where concerns had been raised, necessary action to protect people from further potential harm had not been carried out.

People were encouraged to share their experiences and give feedback to the provider and registered manager about the service. We saw people were consulted about the quality of the service during their six monthly review. This included seeking their views about whether they were happy with the staff that provided their support. When new people started to receive a service, a questionnaire was sent to them after three months to find out whether people were satisfied with the service. Where any concerns or improvements were identified a visit would be arranged to speak with people to resolve any concerns.

Team meetings and senior staff meetings were held and provided staff with an opportunity to raise any ideas or concerns or keep up to date with any developments. One member of staff told us, "It's good that the meetings are at different times. We can't always make the meetings because we are providing care so it's good that we have more than one chance to go." The staff had established relationships with other professionals who supported people in their home. One member of staff told us, "If we get any news or updates from anyone, we share this at these meetings so we all know what is happening." The last meeting discussed the problems staff had experienced when trying to log in and out of their calls in people's homes and how improvements were needed when completing people's records. Staff also informed us they were kept up to date with developments within the company such as changes to how they could claim travel expenses to people's homes.

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	<p>Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>Systems and processes were not established and operated effectively to prevent abuse of service users.</p>
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Regulation 17(1) Systems and processes had not been established to ensure the registered person had assessed, monitored and improved the quality and safety of services provided.</p> <p>Regulation 17(3) The registered person must send a report within 28 days setting out how, and the extent to which, the service is assessed and monitored and risks are mitigated to improve the quality and safety of the service.</p>
Personal care	<p>Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments</p> <p>The provider had failed to suitably display their CQC ratings on their website. This is to make sure the public see the ratings, and they are accessible to all of the people who use their services.</p>

Regulated activity

Personal care

Regulation

Regulation 18 HSCA RA Regulations 2014 Staffing

Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed in the service.