

Bunbury Agency Limited

Bunbury Agency Ltd

Inspection report

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Inadequate 

Is the service caring?

Inadequate 

Is the service responsive?

Inadequate 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Bunbury Agency Ltd is a domiciliary care service providing care to people in their own home. This care included daily support and live-in support. The agency specialises in providing case management and support and is responsible for recruitment, care planning and monitoring of the care and support provided. All carers are self-employed. At the time of the inspection 12 people were receiving 'live-in' support and 25 people were receiving daily support.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support good practice.

Safeguarding policies and procedures were not effective. People were not safeguarded against the risk of abuse. Systems were not in place to ensure referrals were submitted to the Local Authority and people were kept safe. Incidents and accidents reports were not monitored. Management did not demonstrate a clear understanding of safeguarding adults.

There were gaps in the administration of medication which meant we were not assured people were receiving their medication when required. Staff level of competencies were not assessed in line with their company policies and good practice.

Safe recruitment processes were not being followed. Gaps in employment history were not always accounted for.

Care planning was not personalised and people were not involved in the development and ongoing reviews of their care plans. Therefore, we could not be assured care was planned in a way that promoted independence and gave people a choice of how they wanted to be supported.

People's consent was not always sought when required. This meant some people's dignity and human rights were not upheld. Management did not demonstrate a clear understanding of the Mental Capacity Act 2005.

Governance systems were not effective, there was no oversight of the care provided. Feedback from both staff and people was not sought. Therefore, this could not be used to drive any improvements to the service.

Staff did not receive supervisions, this meant staff were not provided with regular feedback on their performance and were not provided time to allow them to reflect on the support they were providing.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

This service was registered with us on 2 September 2021 and this is the first inspection.

Why we inspected

This inspection was prompted by a review of the information we held about this service.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive and Well led sections of this full report.

Enforcement and Recommendations

We have identified breaches in relation to people's dignity and respect, safeguarding people from the risk of abuse and how people's needs were risk managed. Governance systems were also not effective in managing and monitoring the service.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this time frame and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

Please see our safe section of the report below.

Is the service effective?

Inadequate ●

The service was not effective.

Please see our effective section of the report below.

Is the service caring?

Inadequate ●

The service was not caring.

Please see the caring section of our report below.

Is the service responsive?

Inadequate ●

The service was not responsive.

Please see our responsive section of the report below.

Is the service well-led?

Inadequate ●

The service was not well-led.

Please see the well led section of our report below.

Bunbury Agency Ltd

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team

The inspection was carried out by 1 inspector.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own houses. This includes 24 hour live-in care and daily care calls.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post.

Notice of inspection

We gave the service 24 hours' notice of the inspection. This was because the service is small and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We reviewed information we had received about the service and we sought feedback from the local authority.

We used all this information to plan our inspection.

During the inspection

We spoke with 4 people who used the service. We spoke with numerous staff members including the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with external professionals.

We reviewed 6 care records, medication records, and 5 staff personnel files in relation to recruitment. We also viewed various records including policies and procedures in relation to the governance of the service and management.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant people were not safe and protected from avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely

- Risks to people's physical health were not assessed, monitored, or managed safely. Not all People had relevant or effective risk assessments in place. Care plans lacked detail how to support people in a way which would mitigate risk.
- People were placed at risk due to no oversight of care call monitoring. One carer had not turned up to support a person, the provider was not aware of this until the carer the following day raised it.
- Not all staff had received training required to ensure they had the skills to support people safely. We reviewed the care of one person with a specialist care need and spoke with the staff who supported the person. We were told of one occasion when the management team send an untrained staff member to support the person.
- Medicines were not managed safely. We identified a number of gaps on medication administration records (MAR) and examples when people had not received their medicines as prescribed. For example, one person had received a medication for a period of 3 weeks longer than prescribed, another person medication had gone missing and an emergency supply had to be sourced. The management team and nominated individual could not explain these gaps and errors or demonstrate any action taken to keep people safe.
- Not all staff had their competency to administer medicines assessed in line with best practice guidance. There was a risk medicines could be administered by staff who did not have the skills to do so safely.

Systems were not effective to assess, monitor and mitigate risks to the health, safety and welfare of people using the service or to ensure people received their medicines as prescribed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People were not protected from the risk of abuse. Systems were either not in place or were ineffective. The provider had a safeguarding policy in place; however, it was not adhered to.
- Accidents and incidents were logged by staff. Some had been investigated however no actions had been identified or lessons learned shared with the staff. No incidents had been reported to the local authority safeguarding team.
- Following falls, people were not supported to access appropriate medical attention in a prompt manner.
- Staff were not supported to raise a safeguarding referral themselves and lacked understanding in relation to their roles and responsibilities. One staff member told us they were not aware they were able to raise a safeguarding and thought this was the role of the provider.

Systems and processes in place to safeguard people from the risk of abuse were not followed or effective.

This placed people at risk of harm. This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, CQC raised a safeguarding concern with the Local Authority due to concerns identified during inspection.

Staffing and recruitment

- Recruitment processes in place were not always safe. The provider's records did not evidence proper checks relating to safe recruitment were made. Some applications had failed to account for a full employment history.

Systems were not effective for recruiting safely. This is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The deployment of staff was not always effective. One person told us "I have never been without care, when a carer had to go urgently, they [management] found someone else to cover." However, we saw evidence on one occasion a care had not turned up for the evening support call.

Preventing and controlling infection

Systems were in place to protect people from the risk of infections. Staff had access to adequate supplies of personal protective equipment (PPE).

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Individual needs and choices were not appropriately assessed. Care plans were implemented following the family sharing information within the registration forms.
- People were not involved in their own care plans. Care was not planned in-line with person-centred care planning.
- We found gaps in care plans. This placed people at risk of unsafe care as their needs were not being suitably assessed.
- Processes for updating care plans following a change in need were not effective. It is the responsibility of the carers or family member to report any changes to the office. The nominated individual informed us, "carers don't always tell us when there are changes."

Staff support: induction, training, skills and experience

- Staff's competencies were not formally assessed. The nominated individual told us "if they are new they will shadow the lead carers and then they will say whether they are able to carry out their job." We were not assured staff had the necessary skills to provide safe effective care.
- Systems for the oversight of training was not effective. The nominated individual told us it was the carers responsibility to ensure their training was up to date.

Supporting people to eat and drink enough to maintain a balanced diet

- Documentation of people's fluid intake was inconsistent. Fluid charts were not always completed correctly. One person fluid output was documented within fluid amount taken. This placed people at risk of dehydration due to incorrect recordings.
- There was a process in place to ensure all documentation in relation to people's nutritional and fluid intake was recorded regardless of their need.
- Care plans included a section on nutrition and hydration and some care plans had dietary preferences recorded.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- The management team did not have oversight of the support being provided to people. However, carers would support people with any appointments if required and worked alongside other professionals including occupational therapist and district nurses to provide support.

Ensuring consent to care and treatment in line with law and guidance

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 MCA 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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The service was not working in line with the Mental Capacity Act, appropriate capacity assessment and best interest processes were not in place.
- People were not involved in decisions that led to restrictions on their liberty. Not all staff were aware of the importance of least restrictive practice.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity

- The nominated individual discriminated against the people they supported on the grounds of age, when discussing the importance of involving people in their care, they said "most people of that age aren't compos mentis."
- People were not always treated respectfully, one person told us, "They [carers] don't like me interfering and will sometimes move me from the kitchen if I am reading my paper."
- There was mixed view in relation to the support people received. One person told us, "I am happy with the way everything is." However, another person told us "I wouldn't want to say they are not doing their job, think we get on each other's nerves."

Supporting people to express their views and be involved in making decisions about their care

- People were not involved in making decision about their care. All directions, decisions care plans and communication went through family members. This was discussed with the nominated individual. However, they did not demonstrate an understanding of the importance of involving people in care planning.
- People were not asked for feedback on the care they received.
- People were not always given a choice in relation to whether they wanted the support. One person told us, "It was my [family member] who arranged for the manager to come out and see me, I didn't even know, but it is better than being in a care home."

Respecting and promoting people's privacy, dignity and independence

- Some people's privacy dignity and confidentiality were not respected. Not all staff were aware of the need to make sure privacy and dignity was maintained. In one case a persons rights and liberty was being significantly impinged.
- We were unable to see evidence in people's care files to support and promote people's independence.
- Some people did not have their human rights upheld and their dignity was not respected due to restrictions that were in place unlawfully.

We found evidence people were not always treated respectfully and were not actively involved in decision making in relation to how they were supported. This a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Dignity and respect.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People lacked choice and control over how their needs were met due to not being involved in their care planning. One person stated, "I have never seen a care plan, think my daughter always sorts things out although she doesn't always tell me things." Another person stated, "I don't know what a care plan is, never even seen it, maybe they [management] go through my daughter."
- Care planning did not include people's personal history, preferences, interests or aspirations to enable staff to ensure people's preferences and choices were met.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Staff did not always have the appropriate information to ensure people were communicated with effectively. Some care plans contained information regarding people's communication needs however others did not.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Family members were actively involved in the care their family member was receiving. However, permission was not sought from the people receiving care.
- People were supported to do activities they liked. One person told us, "I get a choice of what I want to watch on the telly or I can read or the carer will come for a walk with me."

Improving care quality in response to complaints or concerns

- The system for managing complaints and compliments was not robust. Some concerns were inputted into the report system, but no actions taken to reduce future occurrence or lessons learnt were completed. People did not know how to make a complaint. One person stated, "I don't know the procedures on how to complain. I don't feel like I can because I can't do the things myself." This placed people at risk of not receiving the level of care they required to ensure they are supported safely.

End of life care and support

- Some people were documented as having a do not attempt resuscitation (DNAR) in place. However, the provider had not seen the original documentation for all of these people and it was not on all their files. People were at risk of not receiving lifesaving treatment if required. This was discussed with the management who were aware that without viewing the documentation cardiopulmonary resuscitation (CPR) was to be commenced.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff were discouraged from speaking to the management team and directed to correspond only through the administrative staff or the nominated individual.
- Staff did not feel supported. One person stated, "I don't get supervision, they don't even ring me to see how things are going."
- The management did not demonstrate an understanding of equality and human rights. People's individual needs were often overlooked and they were not valued or respected.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The system for monitoring accidents and incident was not effective. This placed people at risk as no trends or themes could be identified.
- The manager or the provider was not open and transparent when things went wrong. Incidents were not reported externally to other appropriate agencies including the Local Authority safeguarding team or CQC.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Quality performance was not a priority. The provider did not understand the significance of monitoring the service. No audits were completed to enable monitoring of the service and guide improvements.
- Management were not clear on their individual roles and responsibilities or the roles of each other. All tasks was delegated by the nominated individual. No one had a good understanding of the regulatory requirements. Incidents that required a notification to both the Local Authority and CQC were not submitted.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People were not involved in their care. People were not asked for their feedback. One person told us, "They [management] never ring me unless it's to speak to one of the carers."
- Staff did not receive supervision. Staff were not able to discuss their practice and identify any issues that may have arisen, and identify any lessons learnt.
- The service and the managers were task focused and did not encourage interaction with their staff. Staff were actively discouraged from speaking to the deputy manager. Therefore communication was limited. On

discussion with the nominated individual this was due to the deputy manager being too busy.

- The opportunity for people to feedback on their experience of the service was not available.

Continuous learning and improving care

- There was no evidence of learning and reflective practice. There was no system or process that could identify these areas.

Working in partnership with others

- There was no evidence the management team were working in partnership with other agencies. Management relied on staff providing care to liaise with other professionals and feedback any changes to the office for care plans to be amended. There were no systems in place to ensure this happened.
- The provider was not sharing any information with the Local Authorities

Systems were not in place to monitor the quality and safety of the service to identify shortfalls in the provision of safe care. This is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.