Burn Brae Care Limited

Burn Brae Care Limited

Inspection report

81A Front Street
Prudhoe
Northumberland
NE42 5PU

Tel: 01661830111

Date of inspection visit:
16 March 2016
22 March 2016

Date of publication:
19 May 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 16 and 22 March 2016 and was announced. This was so we could be sure that management would be available in the office as this is a domiciliary care service. We last inspected this service in January 2014 where we found the provider met all of the regulations that we reviewed.

Burn Brae Care Limited is a domiciliary care service based in Prudhoe Northumberland that provides care and support to people within their own homes. The care and support provided ranged from 24 hour care packages to short visits, which for example, supported people to access the community, and provided companionship. Services offered ranged from daytime personal care, overnight care, 'sitting services', enabling services and domestic support. At the time of our inspection the service supported approximately 225 people and employed 76 staff. They provided a service in the Tynedale areas including Prudhoe, Stocksfield, Ovingham, Riding Mill, Slaley and Blanchland. People with end of life care needs, dementia, older persons and learning disabilities were supported by the service.

There was a registered manager in post who was also the nominated individual/registered provider of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People spoke highly of staff whom they said supported them safely and in line with their needs. Systems were in place to protect people from abuse and there were channels available through which staff could raise concerns. Records showed that safeguarding matters had been handled appropriately and referred on to either people's social workers or the relevant local authority safeguarding team for investigation. The provider worked collaboratively with these organisations.

People's needs and risks that they were exposed to in their daily lives were assessed, documented and regularly reviewed. Staff supported people to manage health and safety risks within their own homes. Recruitment processes were thorough and included checks to ensure that staff employed were of good character and appropriately skilled. Staffing levels were determined by people's needs and the number of people using the service.

We identified concerns with the management of medicines which we relayed to the provider. These concerns related to the recording of the administration of medicines and practices that staff had adopted which had not been assessed as safe. This included leaving medicines prepared on the side for people to take themselves. Care planning and risk assessments related to people's medication needs were not robust.

Staff told us they felt supported by the provider and received a lot of training but we concluded they were not supported to retain their skills and keep up to date with current best practice guidance as training was not refreshed on a rolling programme. We have made a recommendation about this which you can find in

the body of the full report. Supervisions and appraisals were carried out regularly, as were staff meetings.

CQC monitors the application of the Mental Capacity Act (2005) and deprivation of liberty safeguards. The nominated individual/manager understood their legal responsibility under this act and they assessed people's capacity when their care commenced and on an on-going basis, if necessary. The nominated individual told us that any decisions that may need to be made in people's best interests in the future, would be referred to their care managers and families.

People reported that staff were very caring and supported them in a manner which promoted and protected their privacy, dignity and independence. People said they enjoyed kind and positive relationships with staff and we observed this when we visited people within their own homes.

Care records were person centred and evidenced the provider was responsive to people's needs. People were supported to access the services of external healthcare professionals if they needed support to do so.

People knew how to complain and records showed that complaints were handled appropriately and records were kept of each complaint received. People's views and those of their relatives were gathered through care reviews and questionnaires.

We received positive feedback from both people and staff about the service. Staff told us they found the provider approachable. Auditing and quality monitoring of the service delivered was limited and some systems that were in place were not effective or robust.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were Regulation 12, Safe care and treatment and Regulation 17, Good governance. The provider had also not met their obligations under the Care Quality Commission (Registration) Regulations 2009 as they had not submitted all of the statutory regulations that they were supposed to. We are dealing with this matter outside of the inspection process.

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 managed safely and recording around the administration of medicines was poor.

Safeguarding policies and procedures were in place and records showed that historically these had been followed.

Staffing was tailored to individual's needs and staff generally worked in small teams linked to one or two people.

Recruitment procedures were robust and disciplinary action was taken where necessary.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not supported to access refresher training to ensure their skills remained up to date and in line with best practice guidance.

An induction programme was in place and staff received on-going supervision and appraisal.

Consent was obtained and recorded in people's care records. The provider had a good understanding of their responsibilities in line with the Mental Capacity Act 2005 and best interests decision making.

People were supported to eat and drink in sufficient amounts to remain healthy.

Is the service caring?

Good

The service was caring.

Staff were caring and considerate in their approach and people told us they enjoyed good relationships with staff.

People were encouraged to be as independent as possible and

their dignity and privacy was promoted.

People were involved in their care and said they felt informed about any necessary changes.

Is the service responsive?

Good

The service was responsive.

Care delivery was appropriately planned, regularly reviewed and adjusted when necessary.

Care was person-centred and the service responded appropriately where people were not well or needed support.

Complaints were handled appropriately and thoroughly.

Is the service well-led?

Requires Improvement

The service was not always well led.

Some systems were in place to govern the service effectively and assess the quality of the service provided but these were not robust.

The provider had not adhered to their responsibilities under the Care Quality Commission (Registration) Regulations 2009.

People and staff gave positive feedback about the manager/nominated individual and records showed they worked in partnership with third parties such as external healthcare professionals.

Burn Brae Care 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.

This inspection took place on 16 and 22 March 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the office to assist us. The inspection team consisted of one inspector.

A provider information return (PIR) was requested from the provider as part of this inspection. A PIR provides key information about the service, what it does well and improvements that are planned to be made. We reviewed all of the information that we held about the service including statutory notifications that the provider had sent us. In addition, we obtained feedback from Northumberland Safeguarding Adults team and Northumberland Contracts and Commissioning team about the service. We used the information that they provided us with to inform the planning of our inspection.

As part of our inspection we visited four people within their own homes and spoke with five members of staff including the provider who was also the registered manager and nominated individual. A nominated individual is a person who is named as a 'responsible person' in line with Care Quality Commission requirements, and they represent the provider's organisation. We looked at five people's care records and reviewed a range of other records related to the operation of the service, including six staff training and recruitment files, and quality assurance documentation.

Requires Improvement

Is the service safe?

Our findings

We identified concerns related to the management of medicines. We found there was a lack of instruction for staff about how people needed to be supported to take their medicines and individualised medicine care plans had not been created. Staff were able to tell us what they did when they supported certain individuals with medicines administration, but there was no evidence that this had been formally assessed and documented. Where people were supported with the administration of topical medicines such as creams and ointments, there was no information in their care records about the medicine or the condition this was designed to treat, where on the person's body the topical medicine was to be administered, how, and how often. Body maps were not used by the service to assist and inform staff. This meant staff did not have appropriate the information they needed to administer medicines safely and appropriately and consequently there was a risk to people's health and wellbeing.

We reviewed the medicine administration records (MARs) of the people that we visited and found that recording around the administration of medicines was poor. For example, codes were used to reflect the medicines administration process, but only two different codes were referenced with explanations on the MARs that we viewed. Other undefined coding was used by staff. This meant we could not identify what had happened in respect of medicine administration at each care visit. We also found unexplained gaps on MARs where there was no record of whether the person had received their medicine at a particular visit or not. This meant there was not an accurate record maintained of the medicines people received and the support they were given by the service. This is not reflective of the Royal Pharmaceutical Society best practice guidance about record keeping of the administration of medicines (in a domiciliary care setting).

We visited one person in their own home and found that the administration of their medicine was not safe. We saw that medicines they were due to take at a specific time had been left out for them to take independently but no care planning or risk assessment around this practice had taken place. The staff member who had visited the person's home prior to our arrival had already signed the MARs to say that, at their care call, the person had taken their medicine. We saw that they had not. This meant that staff were not following best practice guidance about the safe administration of medicines. They had confirmed in records that the person had taken their medicines when in fact they did not witness this and therefore could not confirm it.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 entitled Safe care and treatment.

Other risks that people were exposed to in their activities of daily living had been assessed and mitigated against as had environmental risks within their homes. Pre-admission assessments which took place before people started using the service highlighted where there were risks, such as slippery floors, and the precautions people and staff should take to prevent accidents and injuries. There was also detailed information about moving and handling and how to reduce risks to both people and staff being injured during personal care. A sheet was present within people's care records to monitor any accidents or incidents that may have occurred and these were reviewed by the provider.

A business continuity plan was in place which gave instruction to management and staff about what to do in the event of a situation such as a reduction in staffing levels or loss of technology systems. The provider told us that several staff had four wheel drive vehicles so that in the event of adverse weather conditions such as snow, people in more remote areas of the region could still be reached and receive care as normal.

Safeguarding procedures were in place and we saw that historic matters of a safeguarding nature had been reported to the relevant local authority safeguarding adults team for investigation. Staff that we spoke with were aware of their own personal responsibility to report matters of a safeguarding nature and they were familiar with the different types of abuse.

There was a policy in place linked to the management of people's money and set instructions for staff to follow around handling people's cash for example if they were assisting them with shopping or to do their personal banking. Systems that were in place to support people with their minor financial affairs were robust. The provider had taken steps to safeguard people from financial abuse.

Staffing levels were determined by people's needs and the provider told us that staff were matched to people that they supported and generally worked in small teams supporting individuals exclusively. People we spoke with told us there were no issues with staffing levels and there were enough staff to meet their needs. An electronic allocation system ensured that where there were any gaps in staffing due to for example, sickness or annual leave, these were covered by other members of staff who working for the service.

Recruitment procedures were robust and included checks on prospective staff's identity, character and employment history. Prospective staff were interviewed, given contracts of employment and observed for a probationary period of three months to ensure they were suitable for the role for which they were employed. Disciplinary action was evident in staff files where matters of this nature had arisen. This showed the provider had measures in place to ensure that staff they employed were of suitable character to work with vulnerable adults and they remained suitable for their roles throughout their employment.

People told us they felt safe when they received care from staff. One person said, "I feel comfortable with them (staff). I really do feel comfortable". Another person told us, "Oh I am pleased with them (staff)".

Requires Improvement

Is the service effective?

Our findings

Staff told us they had the skills they needed to fulfil their caring responsibilities and people confirmed this. One person said, "Most staff seem to know what they are doing". A second person commented, "They are good; they know how to help me". Other comments included, "The lasses (staff) help you with everything, they really do" and "They help me with having a bath".

Staff training records showed that training in key areas such as medicines, safeguarding and first aid had not been renewed for several years. We found little impact on people, although staff competencies in medicines administration needed to be reviewed in relation to our findings about medicines management. Specialised training in areas such as dementia awareness and end of life care was limited to small numbers of staff who needed it in line with the care packages that they supported. Staff we spoke with told us that they would appreciate refresher training in key areas to ensure they were kept up to date with changes in best practice, but that they felt they had received a lot of training over the years. We fed back our concerns about updating staff training to the provider, and they took steps before the end of our inspection to address this.

We recommend the provider arranges refresher training in key topic areas, so that staff are equipped with the most up to date knowledge and skills related to the roles for which they are employed.

Staff told us they felt supported by the provider who had a supervision and appraisal system in place. Supervisions are one to one meetings between staff and their line manager in which discussions about on-going performance, personal issues, training and any other concerns can take place in confidence. Appraisals are annual reviews of staff performance. In addition staff competency checks on the care they delivered were undertaken regularly throughout the year and a new medication competency check was being introduced as part of staff performance monitoring.

An induction programme was in place which staff told us equipped them for their jobs. This induction involved working through a topical booklet and shadowing experienced staff before being deemed competent to work alone. Staff were issued with an employee handbook when they started working for the service which provided them with information about policies and procedures relevant to their work.

Consent to care and treatment had been considered and there was evidence in people's care files that consent had been obtained, for example, for the administration of medicines by staff where this was an agreed task and also consent to share personal information with relevant healthcare professionals and other important persons.

The Care Quality Commission (CQC) is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be

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

We discussed the Mental Capacity Act (2005) and Court of Protection orders to deprive people of their liberty in a domiciliary setting, with the provider. They told us that people's cognitive abilities were assessed at the point the service commenced and then afterwards, if necessary. The provider was clear about their responsibilities in line with the Mental Capacity Act 2005 and decision making for those people who may lack the capacity to make decisions for themselves. We discussed the needs of people currently supported by the service and the provider informed us that no person lacked the capacity to make their own decisions at the present time. The provider also confirmed that no person currently using the service was subject to a court of protection order to deprive them of their liberty in a domiciliary care setting. The provider informed us that should any concerns or issues arise in the future in respect of a person's capacity levels, they would liaise with their care managers to ensure that capacity assessments were carried out and decisions made in people's best interests.

People were supported to eat and drink in sufficient amounts to remain healthy. They told us that staff encouraged and supported them to eat and drink regularly and records were introduced to monitor people's food and fluid intake where there were concerns about their health and wellbeing. We noted that some of these historic food and fluid records were not always well maintained and some mealtime entries had not been completed.

The provider showed us feedback from healthcare professionals which demonstrated the service engaged with them about changes in people's needs. Email exchanges that we viewed showed the provider ensured people received on-going healthcare support from care managers and other specialised healthcare professionals. There was evidence in people's care records that the service supported people to attend healthcare appointments in order to maintain their general health.

Good

Is the service caring?

Our findings

People told us that staff were caring in their approach. One person told us, "They (staff) are all lovely; they really are". Another person said, "The carers are lovely. They are very nice". We reviewed thank you cards and compliments received within the service and noted two comments from relatives which read, "Thank you as always for your caring care" and "Thank you so much for the natural kindness and compassion that you offered both X (person) and our family".

Our own observations of the care that we saw being delivered was that staff adopted a professional, friendly and mindful approach when supporting people. People were comfortable in the presence of staff and told us that they enjoyed good relationships. They told us that staff made them laugh and they enjoyed "banter" when they visited, which was important to them for their mental health. This showed that staff engagements and interactions promoted people's wellbeing.

People were treated with dignity and respect and staff promoted people's right to privacy. When we visited one person in their own home, staff closed the bathroom door when supporting them, so that the delivery of personal care was not observed. People told us that staff always spoke to them with respect.

People's independence was promoted and they told us that they did as much as possible for themselves and care workers delivered care only in aspects of daily living that they could not manage alone, for example, such as bathing. One person told us, "I do what I can for myself".

Records showed that people were involved in their care. They had signed documentation to evidence that they were involved in decision making and were aware of the contents of their care plans and risk assessments. People also told us they felt informed by staff and the provider, and they had no doubt they would be contacted should any changes to the service or their care package be necessary.

The provider told us that nobody in receipt of their service had a formal advocate in place to his knowledge but that the service acted in people's best interests and advocated on their behalf whenever necessary. An advocate acts on behalf of a person who does not have the capacity to make or understand decisions for themselves. The provider told us that should an advocate need to be arranged for someone, this would be done through liaison with their care manager.

Good

Is the service responsive?

Our findings

People told us that staff responded well to their needs and assisted them in any way they could. One person commented, "They do everything that I need them to. I can't fault them at all. They will do anything I want". Staff told us they responded to people's needs as much as possible in line with the care and support packages that were in place.

The provider told us a structured process was in place prior to people starting to use the service whereby "Care coordinators" carried out initial assessments of people's needs, with the person themselves and their family members (if required or desired), to establish how care was to be delivered. The provider advised that the care coordinators role was to match and introduce staff with the correct skills to the person being supported, and introduce them. At set intervals care coordinators or staff relations officers visited people in their homes to review their care packages and gather feedback about the service delivered. There was evidence in people's archived care records that changes had been made to their plans of care as their needs had changed. This showed care was appropriately planned, reviewed and adjusted accordingly.

Care plans and risk assessments were based on care packages agreed with people or their care managers, prior to them accessing the service. There was information about people's needs and preferences, and what level of support they needed to complete activities of daily living such as eating and bathing. There were agreed routines and tasks for care workers to complete during each specified care visit to people's homes. People who needed more specialised support for example in relation to transferring position, had detailed moving and handling plans in place. This showed care delivery was person-centred and specific to individual's needs.

Care records showed the service were responsive in the respect that where people's health conditions needed monitoring they had worked with external healthcare professionals and completed specific charts to track any changes in people's needs. In addition, there was evidence that the provider had contacted people's GP's where they had presented as unwell. Daily records were maintained to reflect the care delivered at each care visit and any other important information but these were task based and could be more informative about the individual.

People told us they were empowered to make their own choices and if social support was an agreed part of their care package, staff supported them to access the community or social events of their choosing. We saw people were offered choices when staff supported them for example about what they drank and ate.

Information about how to complain was retained within people's care records within their own homes. People told us they had not had a reason to complain to the service but that they would feel comfortable in raising any concerns they may have in the future to either staff or the provider directly. We reviewed the provider's complaints log within the service and this showed three low level complaints had been raised within the last twelve months. In each case the provider had taken steps to deal with the issues raised, and they had recorded the actions taken and achieved a satisfactory outcome for all parties. This showed the provider handled complaints appropriately.

Requires Improvement

Is the service well-led?

Our findings

We identified some shortfalls in relation to the governance of the service.

The provider told us that feedback from people was sought via regular three monthly reviews of their care carried out in person by care coordinators. A matrix was in place to monitor the completion of these, although this highlighted that a number of reviews had fallen behind the timescales the provider had set. We saw examples of "client reviews" that had been carried out and these included discussion about people's current care plan, whether their needs were met, the standard of service provided and any concerns with the care workers supporting them. At the back of these reviews the provider had drafted an action plan detailing any actions that needed to be taken, such as more support being arranged.

The provider informed us that questionnaires to gather feedback were also sent out to people every six months, but three out of four people that we spoke with could not recall receiving or completing such a questionnaire. There were no questionnaires sent out to relatives or external healthcare professionals. We discussed this with the nominated individual who said they would review the use of questionnaires and how widely they were distributed in the future.

The provider also had a matrix in place to track one to one meetings and competency assessments of the care staff delivered. These assessments were said by the provider to be carried out every three months, but the matrix showed some staff competencies had not been assessed since August 2015. Medicines competency assessments were not in place, although a tool related to this had been drafted to be introduced imminently. A training matrix was in place but this was not up to date on the first day that we visited and when this was redrafted by the deputy manager, it showed that training in key areas had not been refreshed, supporting our findings identified in staff records.

Care coordinators held responsibility for auditing people's care records during visits to their homes to carry out reviews of care. The provider told us that daily notes and MARs were brought into the provider's head office at various intervals but these were not reviewed or audited at that time. This meant that although there was a review of these records at any one point in time by care coordinators, between these review dates, there was no continual auditing of these records to identify if there were any concerns. We identified concerns with MARs records in terms of the recording of the administration of medicines, as referred to in the 'Safe' section of this report, and this was not identified by the provider.

There was also no overview of safeguarding concerns or incidents within the service and although we were satisfied that matters of a safeguarding nature were dealt with appropriately the provider could not inform us of how many incidents there had been as there was no system in place to log and monitor these and to identify any emerging patterns that may need to be addressed. We discussed this with the provider who said that they would consider a review of this as part of their overall monitoring of the service.

We found that some systems and tools were in place to govern the service, but they were not always used and followed effectively. Gaps existed in some systems and processes designed to monitor care delivery and

other areas of the business, and this was demonstrated by the shortfalls we identified in staff training and staff competencies related to medicines. The nominated individual told us he would take our comments on board, and review governance and quality assurance within the service, with a view to introducing more robust systems.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled Good governance.

People told us they thought the service was well led. One person commented, "Oh I think it's good; I am sure they tell me what I need to know". Another person commented that the service ran relatively smoothly and they were "generally happy with Burn Brae overall".

The service had a registered manager in post who had been registered with the Commission to manage the service since October 2010. The registered manager was also the nominated individual of the organisation. Staff spoke positively about the manager/nominated individual saying they found them supportive. Records showed that the provider worked in partnership with other organisations and individuals involved in people's care such as healthcare professionals and family members.

The ethos of the service was reflected within their aims and objectives. These read as, "Our aims and objectives are in providing support to enable our clients to be cared for in their own homes for as long as possible. All necessary and appropriate care and support will be provided to achieve this objective. The physical and emotional needs of the client are paramount. Our aims are to meet and sustain the standards set whilst providing our clients with quality care and support". People's feedback was positive and showed that the provider achieved their aims. One person commented in a card, "Thanks again. You made such a difference" and another person told us, "I can't fault them".

We looked at whether the provider was meeting the requirements of their registration and found a small number of deaths that had not been notified to us in line with the requirements of the Care Quality Commission (Registration) Requirements 2009. We are dealing with this matter outside of the inspection process.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected against the risks associated with medicines as medicines were not safely and properly managed. Regulation 12 (1)(2)(g).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected against risks associated with poor governance as robust systems to monitor the quality of service provision were not always in place. Regulation 17 (1)(2)(a)(b).