Bramley Home Care Limited

Bramley Home Care Sherborne

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 7 and 8 November 2018 and was announced. This was our first inspection of this service. It was registered on 11 December 2017.

Bramley Home Care Sherborne provides domiciliary support services to people in their own homes. It provides a service to older people and younger adults some of whom have a physical disability, sensory impairment or dementia. At the time of our inspection there were 20 people receiving personal care from the service.

Not everyone using Bramley Homecare Sherborne received a regulated activity; the Care Quality Commission (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.

The service did not have a registered manager in post. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager of Bramley Home Care Shaftesbury told us they had recently had their registered manager's interview with the CQC and were awaiting the outcome to see if they had met the requirements to become the registered manager of Bramley Homecare Sherborne. In the interim the service was overseen by a full-time office manager.

People were supported by staff who had received safeguarding training and understood how to keep people safe from harm or abuse. Risks to people were assessed and managed. The service had a recruitment and selection process that helped reduce the risk of unsuitable staff supporting people.

People received their medicines on time and as prescribed by staff that had received the appropriate training and competency checks. Staff understood the importance of infection prevention and control and wore protective equipment appropriately when supporting people. Learning from accidents, incidents and near misses was analysed and shared with the team to reduce the chance of them happening again.

People's needs were assessed with their involvement and, where appropriate, those important to them. People were consulted with about changes to their care plans and reviews. People were supported by staff who had an induction and an ongoing programme of training. Training covered mandatory topics and areas specific to people's needs such as multiple sclerosis and diabetes. Staff received regular supervision and checks of their competency. People were encouraged and supported to eat and drink sufficiently.

The service understood the important of keeping people healthy by timely contact with health and social care professionals. Where people's health needs changed staff supported and encouraged people to contact health professionals such as GPs and community nurses. Staff supported people in line with the

principles of the Mental Capacity Act 2005 (MCA 2005). Where complex decisions were required mental capacity assessments took place and best interest decision meetings were held with involvement from relevant people.

Staff consistently demonstrated a kind and caring approach towards people. People's privacy and dignity was supported at all times. People were supported by staff who were respectful and knew them well. People could make decisions and express their views about the care and support they received. People's privacy and dignity was respected. One person told us, "They are all very discreet."

People were supported in line with their assessed care needs. Care reviews were carried out by the office manager every three months and included a discussion with the person about their current or emerging needs. People were encouraged and, where required, supported to maintain friendships, contact with family and links with the community. Complaints were logged, progress tracked and resolved in line with the service's policy.

People's communication needs were assessed and detailed in their care plans. The service was not currently providing support to any people with end of life care needs but had been involved in discussions with people about their future end of life wishes when they had expressed a wish to do so.

There was an open and supportive culture at the service. Staff were encouraged to contribute their views and ideas. People were supported by staff who got on well with each other and enjoyed working for the service. One staff member said, "I'm really happy working here."

Staff told us they felt supported and listened to. Communication between care staff and the management was good. The management kept people, relatives and staff up to date with developments in the service including via a newly created newsletter. People and staff had the opportunity to feedback through six monthly surveys. Regular staff spot checks were carried out with feedback given both individually and as a team. The service was aware of its role alongside partner agencies, such as GP surgeries and community nursing teams, in helping meet people's fluctuating and wide-ranging health and social care needs.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were supported by staff who had a good understanding of how to safeguard people from abuse or harm.

Each person had risks assessments in place. There was an ongoing programme to make these more personalised.

There was a robust recruitment and selection process which meant risks to people from staff that supported them were minimised.

Medicines were managed safely. People received their medicines on time and as prescribed.

Staff understood their responsibility with infection prevention and control and made appropriate use of personal protective equipment.

The service logged and analysed accidents and incidents and used this information to learn how to prevent them happening again.

Is the service effective?

Good

The service was effective.

People were involved in the assessment of their needs, abilities and preferences.

People were supported by staff who contacted health and social professionals when required to help maintain people's health and well-being.

People were supported by staff who were well trained.

People were supported by staff who supported them in line with the principles of the Mental Capacity Act 2005 (MCA 2005).

Is the service caring?

Good

The service was caring.

People were consistently treated with kindness and respect.

People were supported by staff who knew them well.

People's privacy and dignity was always respected by staff.

People were encouraged to remain as independent as possible.

Is the service responsive?

Good

The service was responsive.

People received support that was person-centred. There was an ongoing programme to make these more personalised.

People knew how to complain and had confidence that issues would be investigated. Complaints were resolved in line with the service's policy.

Staff discussed people's end of life wishes with them and, where appropriate, their relatives.

Is the service well-led?

Good

The service was well-led.

Although the service did not have a registered manager the provider had taken satisfactory steps to recruit one to the post.

Staff felt happy, supported and motivated in their roles.

Staff felt their work was valued and recognised.

Audits were completed to ensure the quality of the service.

People, relatives and staff felt consulted and involved.

The service had established and maintained good working relationships with partner agencies.

Bramley Home Care Sherborne

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 7 and 8 November 2018 and was announced. The provider was given 48 hours' notice. This was so that we could be sure the office manager was available when we visited and that consent could be sought from people to receive home visits from the inspector.

The inspection was carried out by one inspector. We visited the office location on the first and second day to see the interim manager and office manager and to review care records and policies and procedures. On the first day the inspector also carried out general observations and checked care records during five visits to people in their homes. The people we visited had given their permission for this to happen.

Before the inspection we reviewed all the information we held about the service. This included notifications the service had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive.

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.

During the inspection we visited five people in their own homes and discussed the delivery of care. We also spoke with three relatives. We met with the interim manager, office manager and the care coordinator. We spoke with eight members of staff (one of these via email). Following the site visit we had telephone

conversations with four people and two health professionals.

We reviewed five people's care files, policies, risk assessments, complaints, quality audits and the 2018 quality survey results. We looked at five staff files, the recruitment process, staff meeting notes, office emails to care staff, training, supervision and appraisal records.

We asked the interim manager to send us additional information after the visit including premises risk assessments, accidents and incidents logs and staff survey results. We received this by the date we had requested.

Good

Is the service safe?

Our findings

People were supported by staff who knew how to keep people safe from harm or abuse. Staff told us, with confidence, what symptoms may indicate that a person was experiencing harm or abuse and how they would raise any concerns.

People felt safe. Comments included, "I feel safe and that they know what they're doing" and, "I feel safe and comfortable with the carers." A relative said, "I feel [relative] is safe in their hands."

People had risk assessments to help reduce risks associated with things such as moving and handling, choking, falls, the use of bed rails and sensory impairments. For example, one person's assessment noted that they had recently become visibly impaired. Staff were reminded to ensure there was good lighting and were near to the person when speaking with them. Another person had a falls risk assessment which advised staff to keep all pathways around the property clear and encourage the person to wear appropriate footwear. Staff demonstrated a good understanding of the risks people faced and how they supported them to minimise these without being restrictive. Risk assessments were reviewed every six months or earlier if required. There was an ongoing programme to ensure each person's risk assessments were more personalised with a deadline for completion at the end of January 2019.

General environmental risks were also considered including those related to the person's property, infection control and fire. Carers tested people's smoke alarms and, with their consent, referred people to the appropriate service if concerns were identified. This support meant people were at less risk from a fire and could receive timely support from emergency services if they had an accident or became unwell in their home.

The service had a business contingency plan which included sharing national weather alerts with staff and prioritised visits to people considered the most vulnerable. Staff were given advice and equipment to help them stay safe when driving and visiting people on winter evenings.

There were enough staff to support the number of people they visited. Due to the size of the service people were supported by a consistent group of staff which meant they got to trust and know them well. One relative said, "There is a small, close knit team so they can build a rapport with people. We like that. We know the staff. They are familiar."

People commented positively about the timeliness of the visits and receipt of their weekly rotas which they could choose to have by post and/or email. One person said, "All the staff are very punctual. I have no complaints." Staff told us they had enough time to travel safely between visits. The care coordinator used dedicated software to create staff rotas and help the service respond flexibly to short notice changes, training or sickness.

The service had safe recruitment practices. Checks had taken place to reduce the risk that staff were unsuitable to support vulnerable people. Pre-employment and criminal records checks were undertaken.

Records included photo identification, interview records and references which provided evidence of previous conduct.

Medicines were managed safely. People received their medicines on time and as prescribed. Where people required extra support with their medication, for example if they were experiencing difficulties swallowing tablets, staff sought timely advice from health professionals to ensure that they followed best practice and risks to people were minimised. We looked at five people's medicines administration records. These were complete and legible. The service had supplied staff with homely remedy guidance and included this within care plans. These are also known as 'over the counter medicines' and differ from prescribed medicines. A recent staff meeting had included a medication quiz to help staff learn more about this area of their practice. Each staff member was given individual feedback. Where people required topical creams, there were clear instructions for staff on how much to apply and where.

Staff were trained in infection prevention and control. They told us they received a good supply of Personal Protective Equipment (PPE) such as disposable gloves and aprons. Supplies were held at the office. We observed that staff used this equipment appropriately when supporting people.

The service recorded and analysed accidents, incidents and safeguarding issues. They used the information to understand what had gone wrong, what could have been done better and what lessons had been learnt. This helped to reduce the chance of them happening again. For example, where a person had had a visit incorrectly cancelled it was found that this probably resulted from a larger than typical number of cancelled visits that day. More scrutiny was put in place on such occasions to ensure this was not repeated.

Good

Is the service effective?

Our findings

People had a thorough assessment prior to them receiving a service. This captured their needs, abilities and preferences including whether they would prefer a male or female carer. It also identified people's wide-ranging needs such as the importance of their pets to their well-being, their sexuality, and their faith. In one case this had led to care visits being altered to a later time to accommodate a person's wish to attend church. One person told us, "I rate the care I receive as excellent."

People were supported by staff who had an induction that included shadowing more experienced staff and formal competency checks. These checks covered areas such as medicines and the use of moving and handling equipment. Staff only successfully completed their probationary period when they were judged as confident and competent enough to support people in meeting their assessed needs.

Staff received ongoing training to help them meet people's specific needs. Staff training had included: Parkinson's, diversity, dementia, safe handling of medication and mental capacity. Two staff members told us, "There is a lot of training on offer. The office manager said that when I had done [various courses] there are other training options available" and, "Bramley have trained me really well so I'm confident on my own with clients." People's comments included, "They all know what they are doing" and, "I have confidence in their skills."

Staff received regular supervision where they could raise issues freely and were encouraged to think about their professional development and how they could improve their practice. Upcoming training courses included initial assessments, care plans and review and person-centred recording.

People were encouraged to eat and drink sufficiently to maintain their well-being and support was given where this was required. Staff understood people's dietary needs and any food allergies they had. People told us that the staff always offered them a choice of food and drink. Daily notes revealed that people had been offered foods that were their favourites. Staff marked opening dates on food items to reduce the risk that people would eat food that was not fit for consumption.

The service understood the importance and benefits to people of timely referral to health and social care professionals to help maintain people's health and well-being. Where people could do this themselves, such as making appointments to see a doctor or dentist, staff encouraged them or provided them with gentle reminders.

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. Our observations and records showed that staff were working within the principles of the MCA. The service held a list of people who had representatives with the legal authority to make decisions on their behalf should they lack capacity. The list detailed the scope of the authority these representatives had for

example for decisions around property and finance and/or health and welfare. We noticed two examples where representatives had signed when they did not have the correct legal authority. When we raised this with the management they took immediate steps to resolve this. Where complex decisions were required mental capacity assessments took place and best interest decision meetings were held with involvement from relevant people.

Good

Is the service caring?

Our findings

Staff consistently demonstrated a kind and caring approach towards people. On occasions people had new carers these were accompanied by a more familiar carer and introductions were made. One person said the carers were, "All friendly. They talk to me in a kind and respectful way." We saw positive, natural interactions between people and the staff supporting them.

People and staff were heard sharing stories about current events, family or shared interests. Care plans noted people's achievements and skills. For example, one person's plan noted that they were 'artistic and creative.' Another person's plan detailed that staff should 'listen and show you are listening' and to 'interact positively discussing hobbies and interests.' One relative told us, "I like the way the staff write their daily notes." Another relative said, "They are all polite, gentle, and caring. They give [relative] their time. When [relative] had an upset tummy that sat with [relative] to provide reassurance. I want [relative] to have the best care. What they all do here is perfect."

People and their relatives told us that they could make decisions and express their views about the care and support they received. One person said, "I feel staff understand I'm the decision maker." A staff member said, "We always consult people to hear what they want and use questions like 'do you mind?' when we are looking to support them." One person told us they usually liked a wash on a certain day but had changed their mind that day and staff had been happy to accommodate this. Another person's care plan advised staff to 'encourage [name] to use their trolley although [name] currently does not wish to use this.' This demonstrated that people could influence the care and support that they received. One relative said, "The staff let us know if [relative's] skin flares up. We feel part of things. Our [relative's] care is paramount to us." The relative added, "Support is always given at [relative's] pace and is what [relative] asks for. They are very understanding like that."

People's privacy and dignity was respected. Staff knocked and waited until they had permission before entering the person's property. Staff recognised that it was the person's home and acted accordingly. Staff introduced themselves on arrival so that people were clear who was there to support them. Before people were supported with personal care the staff sought the person's permission and took steps maintain their dignity, for example by covering them with a towel, removing themselves to another room, or by closing curtains. One person told us, "They are all very discreet."

People were actively encouraged to remain as independent as possible. People told us this and records confirmed it. One person told us, "They are not pushy. I have my independence. They certainly don't take over." Another person mirrored this when advising us, "They support my independence. They don't take over. I wouldn't let them." A staff member said, "It would be easy to dive in and do everything but that would be wrong." One person had recently been supported to have a ceiling track hoist put in their home as a replacement for the manual hoist that they and staff had previously been using. This new equipment had empowered the person as they were able to control their own moving and positioning with the use of a remote control.

Good

Is the service responsive?

Our findings

People were supported in line with their assessed care needs. These were clearly detailed in their care plans alongside guidance for staff on symptoms involved with particular health conditions and how to respond. We observed staff supporting people in line with what had been recommended and with what people wanted. One person advised us that the carers "were first class, just right for my personality. They did everything we wanted them to do. I would most certainly give them ten out of ten. There was nothing they could have done better. They look after me well." Another person said, "They make life easy for me", while their relative added, "It's given me piece of mind."

Care plans included 'This is Me' documents which were put together by people, relatives and their carers. These detailed people's individuality and helped build rapport between the carers and people. One person had wanted it noted that they liked to 'sleep with the lights dimmed low.' The service told us they had consulted with a local authority quality improvement team when developing the new format care plans.

People were encouraged and, where required, supported to maintain friendships, contact with family and links with the community. One person was supported to go out on short walks to maintain the strength in their legs. Another person was accompanied to a dance class which was helping them to overcome some of the constraints that their particular health condition imposed on them. Quotes from people had, with their permission, been placed in the office window. This had drawn the public's attention including that of a local poet who had dropped by to add a poem to the display.

The service had a complaints policy and people told us that if they had a complaint they would be confident it would be resolved quickly. Complaints were logged, progress tracked and resolved in line with the service's policy. The office manager contacted people each month to give them the opportunity to report things that they felt were best reported to the manager. Feedback was also sought at this time and was used to produce an action plan. People had expressed their satisfaction with the service they received and the attitude of the staff. One person had stated that the staff were 'a happy bunch, very professional and show good confidentiality.' This compliment was passed on to staff.

The service kept a 'customer compliments log' which included comments such as: 'Could I take this opportunity to personally thank those carers who attended [relative] over the last two weeks. All things went smoothly which gave me peace of mind while on holiday' and, 'Thank you very much for everything you have done for [name] this year. Please pass on all my thanks to them…It has been a huge support for which I and the rest of [name's] family have been very grateful.' All compliments were passed on to the staff via a daily email. One advised a staff member that a person considered them to be 'an exceptional carer.'

The service met the requirements of the Accessible Information Standard (AIS). This is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. People's communication needs were assessed and detailed in their care plans. This documented the person's preferred method of communication, any impairments that could affect communication, and guided staff on the best ways to communicate with them. For example, where

people required information put in a different format, such as larger print, this was done.

At the time of the inspection the service was not supporting any people who had end of life care needs. However, where people had expressed a wish to do so, staff had talked to them about their future end of life wishes and recorded this in their care plans. We found that some people had a Do Not Resuscitate (DNR) in place and those that did had this recorded in their care plans. A DNR, also known as no code or allow natural death, is a legal order written either in the hospital or on a legal form to withhold in respect of the wishes of a person in case their heart were to stop or they were to stop breathing.

Good

Is the service well-led?

Our findings

The service did not have a registered manager in post at the time of the 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. Although there was no registered manager in post the office manager from another of the provider's domiciliary support services was currently awaiting the outcome of their registered manager's interview to become the registered manager of Bramley Care Sherborne. The office manager from the other domiciliary support service provided regular support to the Sherborne office manager.

Communication between care staff and the management was effective. The office sent out an email to care staff each evening to ensure they knew who they were required to visit the following day and any key information that they needed to know, for example a change in a person's health, how to stay safe on winter evenings, or how to access people's property. One staff member said, "They are supportive with their emails and always let us know what is going on."

Staff meetings were held bimonthly and were usually well attended. If staff were unable to attend, the minutes of the meetings were made available to them. The meetings covered a range of topics including training, how to support people in life-threatening emergencies and the welcoming of new staff. Staff felt included and encouraged to contribute their views and ideas.

The management kept people, relatives and staff up to date with developments in the service. The service had recently created and distributed a monthly newsletter which included information about new care staff, useful links and seasonal community events. The first issued noted, 'We here at Bramley Care feel communication is key, we want to keep you up to date with any changes and improvements we make, after all they affect you.' The previous issue had acknowledged how some people were not fond of Halloween and so had included a poster for people to put in their windows should they wish to avoid trick or treaters.

Staff told us that they felt respected and valued. People and records confirmed that staff received praise. One staff member's file noted, 'I want to take this opportunity [name] to thank you for all your hard work and dedication…' An email from the office manager to staff concluded with, 'Thank you for all your ongoing support and hard work.' One staff member had been surprised with a card and voucher after taking on extra visits to cover staff sickness. Goals were referred to as 'team goals' which helped to create a sense of a common purpose where everybody had a part to play in improving the service people received.

There was an open and supportive culture at the service. People were supported by staff who got on well with each other and enjoyed working for the service. One staff member said, "I'm really happy working here. I feel I'm fully supported at all times, someone is only ever a phone call away." Due to the nature of a domiciliary service staff can be dispersed and at risk of isolation. The management acknowledged this and had appointed a welfare officer with a national qualification in counselling.

People had the opportunity to feedback through six monthly surveys. These included questions about the friendliness of office staff, whether the package of care was personalised to people's needs, and whether the person would recommend the service to others. Comments included, 'The office staff are great' and, 'The service is excellent.'

The service used monthly action plans to note areas under review, what was required to resolve issues and the timescales by which this would be achieved. Monthly audits were completed for people's care plans, medicines administration records, daily notes and staff files. These were carried out by the office manager who had received auditing training. This training was to be extended to team leaders. The office manager provided feedback to the staff after each of the audits to help share what they were doing well and identify team goals. The staff files audit had identified gaps in employment histories which were then followed up and resolved.

Regular staff spot checks were carried out. These covered areas including adherence to infection control procedures, the wearing of an identification badge, the rapport between the carer and person and whether the person was treated as an individual. Individual feedback was provided, with the offer of 1:1 sessions if required, and any themes identified were shared and discussed with the team.

The office manager carried out care reviews every three months and included a discussion with the person about their current or emerging needs and a check whether visits were happening on time and for the correct duration.

The interim manager and the office manager demonstrated a good understanding of their role and responsibilities including when they needed to notify CQC, the local authority safeguarding team or the police of certain events or incidents such as the alleged abuse or death of a person. They kept their skills up to date by participating in joint training with the sister office staff, by reviewing updates on the CQC website and reading a leading care industry publication.

The office manager had supplied staff with information about specific phone apps that provided evidence based best practice guidance on things such as medicines and health and lifestyle choices. This meant staff had quick access to trusted information which could help them when supporting people in the community.

The service had established and maintained good working relationships with GPs, social work teams and district nurses. The service was aware of its role alongside these partner agencies, in helping meet people's fluctuating and wide-ranging health and social care needs.