The Care Bureau Limited

The Care Bureau Ltd - Domiciliary Care - Stratford- on- Avon

Inspection report

42 Cygnet Court
Timothy's Bridge Road
Stratford on Avon
Warwickshire
CV37 9NW

Date of inspection visit:
08 May 2019

Date of publication:
02 July 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: The Care Bureau Ltd - Domiciliary Care - Stratford- on- Avon provides personal care for people living in their own homes. Forty six people were receiving personal care at the time of our inspection visit.

People's experience of using this service:
People's needs and wishes were assessed before they started to use the service.
These needs and wishes were recorded in people's care plans.
Care plans were regularly reviewed to ensure staff had up to date and relevant information about people's care needs.
Staff knew about the risks associated with people's care and how to minimise these. However, these risks were not always reflected in people's care plans for staff to refer too.
People told us when staff were there, they were caring, kind and knew them well.
Although staff never missed a call, people told us they were much earlier or later than they liked which had an impact on their emotional well-being.
Staff were recruited safely, and processes checked the background of potential new staff.
Staff understood how to keep people safe and how to report any concerns they may have.
Action was taken to safeguard people from abuse. However, statutory notifications for specific incidents were not always sent to us.
Staff supported people to take their medicines as prescribed.
Staff understood how to prevent the spread of infection.
Staff received the training and guidance they needed to complete their role well.
People made their own decisions about their care and were supported by staff who understood the principles of the Mental Capacity Act 2005.
People were offered choices. For example, in the meals and drinks they were offered.
Staff respected people's rights to privacy and dignity.
People received information about the service in a way that was appropriate to their needs
People did not always feel confident to complain
Systems and processes had not always been effective in ensuring the quality of the service delivered

Rating at last inspection: Good. (The last report was published on 8 November 2016).

Why we inspected: This was a planned inspection to confirm that the service remained Good. The service is now rated 'Requires Improvement'.

The registered provider was in breach of regulation 17 of the HSCA (Regulated Activities) Regulations 2014: Governance and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009: Notification of other incidents.

Enforcement: Action we told provider to take (refer to end of full report).

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our inspection programme. If any concerning information is received, we may inspect sooner.

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

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

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective

Details are in our Effective findings below

Is the service caring?

Good

The service was caring

Details are in our Caring findings below

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below

The Care Bureau Ltd - Domiciliary Care - Stratford- on- Avon

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: The inspection team consisted of one adult social care inspector, one assistant inspector and one expert by experience who had experience of caring for people with a learning disability. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type: The Care Bureau Ltd - Domiciliary Care - Stratford- on- Avon is registered as a domiciliary care service. It provides personal care to older and younger adults living with a learning disability or autistic spectrum disorder, dementia, a physical disability, sensory impairment or mental health difficulties. CQC only regulates the personal care provided.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: We gave the service 36 hours' notice of the inspection site visit, so the registered manager would be available. We also wanted to contact people in their own homes and we needed support from the registered manager to ensure people consented to this. However, the registered manager was unavailable and therefore the area manager supported the inspection. The inspection site visit activity started on 7 May 2019 and ended on 9 May 2019. We visited the office location on 8 May 2019 to see the area

manager and office staff; and to review care records, staff recruitment files, medicine records and policies and procedures.

What we did: Before the inspection we reviewed the information we held about the service. This included notifications the provider is required by law to send us about events that happen within the service such as serious injuries. The registered manager had completed a Provider Information Return (PIR). The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

We sought feedback from the local authority and other professionals who work with the service such as Healthwatch. Healthwatch is an independent organisation which collects people's views about health and social care services. The feedback from these organisations was used in planning for the inspection and helped identify some key lines of enquiry. We used all this information to plan our inspection.

Prior to and following our site visit we spoke with twelve people and six relatives to ask about the care people received. We spoke with the area manager, administration assistant, two supervisor's and three members of support staff.

We reviewed two people's support plans in full and specific aspects in other people's care records. We looked at two people's medicine records, induction and training records and other records of how the service assures themselves of the quality of service provided.

Requires Improvement

Is the service safe?

Our findings

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

Requires Improvement: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations had been met.

Staffing and recruitment

● A call monitoring system monitored when staff arrived at a person's home and when they left. This system alerted the office staff when care staff were running late which reduced the risk of people missing their calls.

● However, whilst we were assured care calls had not been missed, records showed people did not always receive the care they required at the time they needed it. 42% of people told us care calls were often later than had been agreed, despite there being an agreed 45 minute period either side of their allocated time. Late calls for some was common practice. Comments included, "The times of calls vary, so it's really not very good. They could be here at twelve thirty (pm) when it's time for my lunch instead of ten o'clock (am)" and "Different peoples timing is different, which affects me. They used to come any time between eight and nine (am/pm) before, but one came before eight, and yesterday one came at ten which is frustrating." Another person explained they were changing care agency due to late calls.

● The area manager and supervisor explained whilst there were enough staff to meet people's assessed needs, short or late care calls were due to short term sickness and annual leave.

● Staff recognised there had been difficulties with staffing levels and told us they had tried to minimise the impact on the care people received. Comments included, "We could always do with more carers. I sometimes feel rushed but give the client the time they need" and "We are struggling a bit to cover. I will always work over if rushed but it does put pressure on us to get the calls done" and "There doesn't seem to be a lot of staff. They are always making me do extra hours".

● A 24 hour on-call system was in place for staff to seek emergency advice when necessary.

● The provider had an effective recruitment process to prevent unsuitable staff working with vulnerable adults. This included checks with the Disclosure and Barring Service (DBS) which checked employees were suitable for working with vulnerable people.

Systems and processes to safeguard people from the risk of abuse

● People and relatives told us people were safe. Comments included, "I do feel safe" and "I feel absolutely safe, very much so."

● The provider had a safeguarding policy that described the different types of abuse vulnerable people might face and included information for staff to follow if they suspected abuse.

● Staff had also completed safeguarding training and knew how to keep people safe from potential harm or abuse. One staff member told, "I would call the manager and report it."

● At the time of our inspection, no safeguarding referrals had been made to the local authority since our previous inspection.

● However, a stakeholder alerted us to an allegation of financial abuse which involved a person who used the service. The provider was aware of this allegation but had not shared it with us during our inspection

visit. We discussed this with the director following our inspection who assured us additional measures had been taken to keep this person safe.

Assessing risk, safety monitoring and management
●Risks associated with people's planned care had been identified and assessed. For example, where people required help to move safely around their home, the number of staff and the equipment needed was documented.
● Staff received additional training where risks to a person's health had been identified. For example, competency checks were carried out with staff supporting people with catheter and stoma bag care.
● However, instructions for staff on how to mitigate risks lacked detail. This meant staff may not carry out all necessary actions to minimise risks to people's safety. We recommended to the area manager to update people's care plans which they agreed to do.
● Despite this, people and staff told us staff knew how to manage these risks.

Using medicines safely
● Records demonstrated that people received their medications as prescribed. Medication administration records (MAR) showed staff recorded people's medicines in line with the provider's policies and best practice guidance.
● Staff had been trained and knew how to support people to manage their medicines safely.
● Staff competency was assessed during their observed practice supervision but this wasn't always recorded. The area manager advised immediate action would be taken to ensure this was recorded.
● The registered manager completed medicine audits to ensure any issues were identified and acted upon quickly.

Preventing and controlling infection
● Staff were trained about infection control and they told us personal protective equipment (PPE) was used to help prevent the spread of infections.
● Infection control practices were assessed during supervisions and discussed at team meetings.

Learning lessons when things go wrong
● Accidents and incidents had been recorded within people's individual care notes and any immediate action had been taken to reduce the risk of the event happening again.
● However, it was not clear if accidents and incidents were analysed centrally by the registered manager to identify patterns and trends and to mitigate on-going risk. We discussed this with the area manager who told us there had not been enough accidents and incidents recorded to analyse.

Good

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

Good: People's outcomes were consistently good, and people's feedback confirmed this. Legal requirements were met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's needs were assessed before they received support from the service. This meant staff could be sure they could meet people's needs.
- Assessments and support plans were reviewed regularly and amended to reflect changes in people's needs. For example, one person's care plan had recently been updated to reflect changes in a person's continence needs.

Staff support: induction, training, skills and experience
- Staff received an induction when they started working at the service which included time working alongside experienced staff to learn about people's needs.
- People told us they received effective care from competent staff who had the relevant training to meet their needs. A person told us, "They are trained before they're allowed to come, so they know what it is they have to do. I have a catheter and a bag that has to be changed once a week and they know how to do it."
- Records demonstrated staff kept up to date with their training and best practice techniques. Staff spoke positively about the training and told us they were happy with the training they had received.
- Staff told us they received regular spot checks and observed practice supervisions from their supervisors to ensure their working practices were in line with the organisation's expectations.

Supporting people to eat and drink enough to maintain a balanced diet
- Staff ensured people had enough to eat and drink. A relative told us, "They leave a drink next to her when they leave."
- Preferences were provided in care plans to guide staff on how to support people with their nutritional needs. For example, one person only ate small amounts and liked a milky coffee with no sugar and the care plan reflected this.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
- Staff helped people to arrange health appointments when these were needed. One staff member told us how they would call the office if they noticed a person was unwell to ensure they got timely support.
- A relative explained how she thought one of the carers was 'really on the ball' with identifying any changes in their family member's health.
- The supervisor told us they worked with other healthcare professionals to make sure people understood their healthcare choices. For example, staff had recently supported one person with a referral to the occupational health team to review their mobility equipment.

Adapting service, design, decoration to meet people's needs

● Where people were identified as being at risk in their home, the service manager arranged assessments to ensure people had the necessary equipment to maintain their safety. For example, one person used a walking stick and another had a 24 hour lifeline system in case of emergency help was needed.

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 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 make 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 with appropriate legal authority. For people living in their own home, this would be authorised via an application to the Court of Protection. We checked whether the service was working within the principles of MCA.

● People told us they made daily decisions about their care. One person told us, "I am asked for my consent". Another person told us how the staff had respected their decision to only have female carers.

● At the time of our inspection visit, every person receiving support had the capacity to make their own decisions about their support needs.

● Records did not always show people had given consent to the way in which their care was planned to be delivered. However, people told us they have been involved with their care plan and that staff were delivering their care in a way they liked. We discussed this with the supervisor who assured us action would be taken to record people's consent in line with the principles of the MCA.

● Staff understood their responsibility to comply with the requirements of the Act and told us "People always have the right to say no."

Good

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

Good: People were supported and treated with dignity and respect; and involved as partners in their care. Legal requirements were met.

Ensuring people are well treated and supported; respecting equality and diversity
- People told us staff cared for them in a kind and caring way. Comments included, "They are all kind and caring", "They show me respect" and "They're all kind as they have a generally helpful attitude."
- Relatives provided positive feedback about the caring nature of staff. One relative told us, "One [staff member] makes sure she's got the right TV programme on" and "The staff are good. He calls them the 'caring ladies' and has a laugh with them and they make him happy."
- Staff enjoyed their role and felt they made a positive difference to people's lives. One staff member told us, "I love the work that I do. It is rewarding seeing a smile on their face."
- Staff received training on equality and diversity and respected people's individual characteristics. However, it wasn't clear if people's cultural needs were explored during assessment and care planning. We discussed this with the area manager and supervisor who explained, due to the demographic area, the population of people needing care was not diverse. However, the service would welcome people from all backgrounds and offer them the support they wanted.

Supporting people to express their views and be involved in making decisions about their care
- People made day to day decisions about their care and staff respected people's right to make choices about how their care was provided.
- People were assigned a specific member of staff called a keyworker. Keyworkers were responsible for maintaining a special relationship with each person they supported and enabled the person's voice to be heard.
- No one currently received support from an advocate; however, the supervisor was aware this should be considered if anyone required some assistance with decision making.

Respecting and promoting people's privacy, dignity and independence
- Staff respected people's privacy and dignity. One staff member told us, "I always make them try and feel at ease."
- A relative commented in a recent survey, "Your care allowed mum to live her last years in her own home with dignity"
- Staff promoted people's independence. One staff member told us, "I try and get them to do as much as they can themselves. For example, I might let her do the top half and I will do the bottom."

Requires Improvement

Is the service responsive?

Our findings

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

Requires Improvement: People's needs were not always met. Regulations had been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● Some people felt that the lack of organisation and staffing difficulties meant they were not receiving personalised care. A relative told us, "Her care is about what she needs rather than what she wants. In the evening she doesn't want to go to bed, but the call times are related to the route the carers have to take." Another relative explained, "The problem is they call nearly every Saturday very late; Saturday is the only day for me to do shopping, so I need to be ready to go out of the door. But when they come at 2 o'clock they've got to do everything before I'm able to be getting out, and it's too late."

● Care plans were written from the person's perspective and were focussed on people's assessed needs and preferences to explain to staff how they wanted their care to delivered.

● People told us staff knew them well. One person told us, "There is a care plan here but they know what to do."

● A relative explained the regular staff go the extra mile and said, "They do a hot water bottle for her when it's cold. Lots of little important things."

● The service ensured people had access to information they needed in a way they could understand it to comply with the Accessible Information Standard. The Accessible Information Standard is a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The area manager explained that whilst this is not necessary for the people they currently supported, documents such as the service user guide can be printed in any language and care plans can be printed in bigger fonts to ensure people have the information they need.

Improving care quality in response to complaints or concerns

● A system was in place to manage and respond to complaints or concerns raised. In the twelve months prior to our inspection there had not been any recorded formal complaints.

● Overall, people and relatives knew how to raise complaints and concerns and felt they would be listened too. However, some people did not feel confident to do so. For example, one relative told us they did not feel confident to complain as a previous concern had not been listened to and they felt fear of reprisal.

End of life care and support

● At the time of our inspection, nobody was receiving end of life care. However, the supervisor explained that if this was required the service would liaise with other healthcare professionals to ensure people received the right care and support.

● Records did not show that end of life wishes had been considered as part of a person's care planning.

Requires Improvement

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

Requires Improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Regulations had not been met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- From speaking with people and relatives about all aspects of their care, we found inconsistent levels of service. Some people were satisfied with the care they received but others were not. More than one person told us they did not feel they could raise a concern with the service. One person told us they had raised lateness as a concern and had not had a positive response. This person went on to tell us, "I just tolerate the lateness." We would expect the provider's systems and processes to promote and encourage people to share their concerns and act in positive ways to improve people's experiences.
- The area manager told us the registered manager completed a variety of audits to assess the quality of care at the service and we were shown some examples of the types of audits completed. However, these audits did not always assess, monitor and improve the quality of the service provided.
- For example, the impact late calls had on people's well-being and instructions for staff on how to minimise risks lacked detail.

This was a breach of regulation 17 of the HSCA (Regulated Activities) Regulations 2014: Governance.

- The management team consisted of a registered manager and three supervisors who received regular support from the provider. Staff spoke positively about the management team. One staff member told us, "The manager is lovely and approachable" and "I know that if I had a problem [Registered Manager] would be there in a shot to help me sort it out. She says, 'my door will always be open for you".
- During our site visit, the registered manager was unavailable, and the area manager and supervisor supported the inspection. Whilst assurance was provided that the registered manager and provider understood their regulatory responsibilities to inform us (CQC) about any significant events that occur in the home such as allegations of abuse, we found one recent incident that had not been reported in line with their regulatory responsibilities.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4): Notification of other incidents.

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

● Staff received supervisions where they were given opportunities to discuss and make decisions related to the service.
● People and relatives were invited to feedback about the service they received and any decisions which impacted on them via a survey. Overall, there was a good level of satisfaction with the quality of care people received. One person wrote, "Everything is done to my satisfaction. Carers are always cheerful when they come."

Working in partnership with others
● The registered manager was keen to work in partnership with others and regularly attended local provider forums. They were developing links with other agencies such as The Alzheimer's Society dementia café to improve the lives of people using their service.
● The supervisor explained that the service is in regular contact with social workers to review people's care needs as they changed. However, this was not always done in a timely way.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to inform us about a significant incident that had occurred at the service. Systems and processes to be improved to ensure statutory notifications are sent without delay.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes did not always assess, monitor and continually drive improvement in the quality of the service provided