Be Caring Ltd

Be Caring Leeds

Inspection report

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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Be Caring Leeds is a domiciliary care service which provides personal care to adults with a range of support needs in their own homes. At the time of this inspection the service was supporting 242 people.

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

People's experience of using this service and what we found
At the last inspection we found the provider was in breach of regulation 12 and 17 as governance systems were not robust and medicines were not managed safely. We also made a recommendation for the provider to improve their staffing. At this inspection we found the service had not made enough improvement and remained in breach of these regulations.

The provider failed to assess, monitor and improve the quality of the service and maintain accurate and robust care records. We found shortfalls in recordings; for example, medication administration records (MARs), care plans and risk assessments were not always signed, updated or completed.

Medicines were not always managed safely. People we spoke with were not confident their medicines were administered at the correct times due to visits being late. Medication administration records (MARs) were not always accurately written or signed for by staff following administrations.

We found evidence staffing levels were not adequate as rota's showed staff did not always stay the allocated times. People we spoke with and their relatives said staffing levels were not sufficient as visits were often late or missed due to staff shortages.

Some care plans lacked up to date and accurate information to guide staff. Risks to people and how they were managed were not always fully reflected in risk assessment documentation. Staff knew people's needs and how to care for them however, some people we spoke with said staff required further training to meet their needs.

People told us they felt safe with staff visiting their homes. There were systems in place to recognise and respond to any allegations of abuse.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. Basic information was recorded for people's capacity status however, decision specific capacity assessments and best interest decisions had not been recorded.

People told us staff were kind, caring and supportive. People's privacy was valued by staff who maintained

people's dignity. Staff ensured they always offered choice and encouraged people to remain independent when their health allowed.

Complaints we looked at were managed with actions taken to address the concerns and most people felt their concerns would be responded to.

Staff were aware of infection control practices in relation to the latest COVID-19 government guidance for the use of personal protective equipment (PPE) to keep people and staff safe.

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

Rating at last inspection
The last rating for the service under the previous provider was rated good (published 4 July 2019). CQC carried out a responsive inspection of Be Caring Leeds looking at the safe and well led key questions and found two breaches of regulation 12 and 17 (published 21 April 2021). The overall rating published on 21 April 2021 was requires improvement.

Why we inspected
The inspection was prompted in part due to concerns received about safe care and treatment. We had been contacted by the local safeguarding team about ongoing concerns within the service. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvement. Please see the safe, effective, caring, responsive and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last focused inspection, by selecting the 'all reports' link for Be Caring Leeds on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified three breaches in relation to safe care and treatment, staffing and governance.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe.	**Requires Improvement**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service caring? The service was caring.	**Good**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not always well led.	**Requires Improvement**

Be Caring Leeds

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team was made up of two inspectors, a pharmacist and three experts by experience. 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
Be Caring Leeds is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager however, they had not yet registered with the Care Quality Commission to become the registered manager. Therefore, the provider was 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 48 hours' notice. This was because we needed to be sure that the provider or manager would be in the office to support the inspection. Inspection activity started on 3 September 2021 and ended 14 October 2021. We visited the office on 7 September 2021.

What we did before the inspection
We reviewed information we had received about the service. The provider was not asked to complete a provider information return prior to this inspection. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. We took this into account in making our judgements in this report.

We sought feedback from the local authority, clinical commissioning group and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used this information to plan our inspection.

During the inspection
We spoke with 14 people and 18 relatives about their experience of the care provided. We spoke with the nominated individual, the manager and staff members. We looked at care and medicine records, staff files for recruitment and risk assessments. We also looked at quality monitoring records relating to the management of the service, such as audits and quality assurance reports.

After the inspection
We continued to seek clarification from the provider to validate evidence found. This included reviewing feedback about the service and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant 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. Assessing risk, safety monitoring and management.

At our last inspection the provider had failed to ensure medicines were managed safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Using medicines safely
• Medication administration records (MARs) did not always have information to guide staff on how medicines should be taken; before or after food, or whether it should be swallowed whole or dissolved in water before giving.
• Some MAR charts had been amended by hand without any reason as to why doses of medicines had been changed.
• Missing signatures did not demonstrate whether people had received their medicines.
• People were at risk of not receiving their medicines at the specific times prescribed due to visits not being carried out at the correct times. For example, some people prescribed paracetamol did not have four hours in between visits to ensure there was enough time in between administrations. Comments from people and their relatives included, "[Name's] tablets aren't given at the right time," "I don't always have my medication on time," and "[Name] doesn't always get her medication on time, if the carers are up to an hour late."
• The provider did not reconcile medicines (to check what the person should be taking). We asked for general practitioner (GP) records for people and found the medicines on the GP's list did not match the medicines on the MAR charts.
• Body maps were not in place to record where a medicines patch had been applied. This meant there was a risk of side effects because the site of application was not being rotated.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate medicines were management safely. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• People we spoke with and their relatives said staffing levels were not sufficient as visits were often missed due to staff shortages or late. Comments included, "Visits are rarely on time, often an hour late. I received a

call from the manager to ask me if I could cover the weekend calls because the company were so short staffed," and "Carers don't always arrive on time. Often, they are half an hour late. Today, my daughter got a call to say the carers wouldn't be calling because they were so short staffed, so I had to get myself ready."
• We were not assured that systems in place to manage and prevent late visits were effective. For example, one internal report showed 35% of visits in the service had been late.
• We looked at staff rota's which showed one staff member did not always stay the allocated times. For example, out of 452 calls a staff member attended, only 71 of the visits were for the full period of time allocated. Most of the visits that should have been for 30 minutes lasted only three or four minutes. The provider had taken disciplinary action with the staff member to address this matter.
• Staff we spoke with told us their calls often over lapped and this did not allow for travel time between visits. Comments included, "They [management] put extra calls on us without asking. We [staff] get pressured to do the calls as they [management] say they [people] won't get care if we don't go. There isn't enough staff at the moment, and we don't have enough time to travel," "Rota's and staffing are a massive issue. We [staff] always have more calls than time we have to do it. We never get travel time. We end up cutting calls short to get to the next call," and "Its horrendous. Constantly changing the times of calls without any reason. There is not enough travel time in between."

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

• The provider had recruitment checks in place to ensure staff were suitable to work in a care setting.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• Risks to people and how they were managed were not always fully reflected in risk assessment documentation. For example, one person used a continuous positive airway pressure (CPAP) machine at night however, there was no risk assessment to guide staff. This was discussed with the provider and actions immediately taken.
• Staff we spoke with understood people's individual risks and how these should be managed. However, people and relatives we spoke with were not always confident staff knew how to manage risk. For example, one relative said, "One morning I came in to see [Name] being washed whilst they were lying down. [Name] cannot breathe while laying down and this is recorded in their care plan."
• Accidents and incidents reported to management had been investigated and actions taken to prevent re occurrences. However, we found the actions taken had not always been recorded on the providers log.
• Staff we spoke with said lessons learnt from incidents were shared via the providers computer app system.

Systems and processes to safeguard people from the risk of abuse
• There were systems in place to help keep people safe and the provider had clear safeguarding policies and procedures.
• Staff knew how to protect people from the risk of abuse. Staff confirmed they had received training in safeguarding and knew who to report concerns to. One staff member said, "It's about making sure vulnerable people are not at risk or at minimal risk from any kind of abuse. Some forms of abuse include mental, sexual, financial or modern-day slavery."
• People and relatives, we spoke with said they felt safe with staff in their homes. One relative told us, "Mum has felt safe with carers visiting her home and if there are problems or issues, they come through me. Right at the beginning we had an issue with one carer who refused to empty mum's commode. But it was dealt with immediately and the carer was never sent again."

Preventing and controlling infection
• Staff told us they were provided with personal protective equipment to use when carrying out personal

care in people's homes to prevent cross infection. People we spoke with said staff wore their PPE when attending their homes. We were assured that the provider was accessing testing for people using the service and staff. We were assured that the provider's infection prevention and control policy was up to date and audits were carried out.

Requires Improvement

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.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
• People and their relatives did not feel all staff had received sufficient training to meet people's needs. For example, one relative told us, "[Name] needs to be hoisted and most of the carers do not appear to understand how to safely use their hoist, which I have observed. Carers have not been trained to provide appropriate and safe stoma care. Carers have no idea how to empty and replace the bag. I have observed carers not rolling the bag up and consequently the bag leaks all over mum and her clothes/bedclothes."
• Not all staff were up to date with their training. The training matrix showed out of 121 staff, 64 were out of date for their moving and handling practical training and 45 were out of date for their moving and handling theory training. These had all been booked for October 2021. We also found 22 staff were out of date for medicines training and 40 staff were out of date for catheter and stoma care training.
• Spot checks and supervisions were carried out to support staff in their practice. However, staff we spoke with said supervisions were not carried out regularly. Comments included, "No, I haven't had a supervision in ages. I haven't had a supervision since it's been Be Caring Leeds, last one was when it was (previous provider name). No annual appraisal," and "I've not had a supervision since starting but I'm on a six-month probation. I've not had any meetings with the managers apart from the trainer who calls to see how I'm doing. I've not had any formal reviews."

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• New staff had an induction programme and completed their training.

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
• Staff had received training on the Mental Capacity Act (MCA) and understood the principles of the MCA. Basic information was recorded for people's capacity status however, decision specific capacity assessments and best interest decisions had not been recorded.
• Staff told us they always asked for people's consent prior to carrying out any person care.

Supporting people to eat and drink enough to maintain a balanced diet, supporting people to live healthier lives, access healthcare services and support;
• Staff supported people to eat and drink according to their preferences and to maintain good health. People told us, "[Name] has a bland diet but carers always give him choices for the food that is available and drinks," and "Carers always ask me what I want to eat, and drink."
• Where people required specialised diets, this was recorded in their care plans. This included things like soft food diets, allergies, and personal dietary preferences.

Staff working with other agencies to provide consistent, effective, timely care
• Relatives said their loved ones had access to health professionals however, the provider did not have effective systems in place to ensure they were informed when changes were made to medicines. For example, the service did not routinely request medication dosage information for people on warfarin. The service said they did not routinely receive this information from the warfarin clinic to ensure people were receiving the correct dose.
• The nominated individual also told us they had difficulties obtaining people's current medication lists from GP's to ensure medicine prescriptions were up to date.

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.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People told us they were treated with respect and supported kindly by staff. Comments included, "Staff are very kind and caring. They do what I want them to do and they do it well," and "Carers are always kind and caring towards [Name]. One carer actually spent time in the garden looking for [Name's] cat when they went missing."
• Staff understood people and supported them with dignity and kindness. One relative told us, "[Name] had fallen to the floor and the carer called an ambulance. It took three hours for it to arrive, so the carer carefully got [Name] changed to make her comfortable before the crew arrived."

Respecting and promoting people's privacy, dignity and independence
• People's privacy was valued by staff. Comments from people included, "Yes, staff do treat me with dignity and respect. I'm happy with the carers," and "When they shower [Name] they give as much privacy as is possible and treat her with dignity."
• People and their relatives told us staff always maintained people's dignity.
• People were supported to remain as independent as possible.

Supporting people to express their views and be involved in making decisions about their care
• People were offered choices such as what to eat and drink, their wishes for care and how they wanted to spend their time.
• People and relatives were asked for their views through surveys and through phone calls. However, some people we spoke with said they had not been asked for feedback about the service.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people's needs were not always met.

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

• Care plans we looked at included some person centred details including people's likes, dislikes and preferences. However, care plans did not always provide clear instructions for staff to follow. For example, care records we looked at did not specifically detail how people should mobilise safely.

• People and relatives provided mixed reviews about their care. Comments included, "Sometimes when relief staff stand in, I don't know who they are and they don't know what to do for me, so it takes a long time to explain what needs to be done," "The majority of carers do not read mums care plan so just carry on and do tasks that are not safe," and "Yes [Name] is quite happy with what carers do for her."

• We saw evidence of care reviews taking place. However, people and relatives we spoke with said they had not been involved in this process. Ten people we spoke with told us they had not been involved in reviews of their care plans. One relative said, "[Name] has a care plan but it has never been reviewed in the ten months he has been receiving support from Be Caring Leeds."

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

• People using the service told us staff interacted with them and formed friendly relationships. One person said, "I think my carers are very good. I don't get any visitors, so it's great to sit down and have a conversation with someone."

• Some people used the providers 'sit-in' services which allowed people to have one to one time for activities and social stimulation. One relative said, "Carers are here for two hours twice per week to do things that [Name] wants to do. It may be going out for a walk or to the shops or doing something at home or just a chat."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• The service understood and followed the AIS and information could be made available in different formats if required.

Improving care quality in response to complaints or concerns

• The provider had a complaints policy and procedures were followed. Investigations had been carried when concerns raised with the service and actions taken.

• Most people and their relatives we spoke with said they felt confident complaints would be managed effectively.

End of life care and support

• Some people using the service were receiving end of life care. We saw advanced statements were in place which guided staff on how best people wished to be supported.

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.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider had failed to ensure systems in place to assess, monitor and improve the quality and safety of the service provided. There was a failure to maintain accurate and complete records. This was a breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

• Governance systems were not robust. At the last inspection we found two breaches of regulation 12 and 17. At this inspection not enough improvement had been made by the service to improve their governance systems and medicines to ensure people's care was safe.
• Records were not always completed or accurate. We found risk assessments had not always been completed, care plans did not always contain relevant information to guide staff and MAR charts did not always accurately record prescribed medicines.
• Relevant checks to ensure people's safety had not been recorded. For example, staff used equipment provided by an external company however, there were no records to show the equipment had been checked to ensure the safety of the equipment.
• The incidents and accidents log did not always record when actions had been taken. For example, one person's medicine patch had not been changed and was overdue by three days. No outcome was recorded as to what had been done to ensure this did not happen again.
• At the time of our inspection there was no registered manager. There was a manager who told us they planned to start the registration process with CQC.
• Management meetings were held on a regular basis however, some outcomes from previous meetings had not been achieved and continued to be put on as actions at the next meetings which demonstrated actions had not been completed in a timely manner.
• Staff, people and relatives we spoke with were not familiar with the management team. Some staff we spoke with could not inform us who the current manager of the service was.
• The service had previously not informed CQC of incidents that occurred in a timely manner. At the

inspection we found all incidents had been reported and the nominated individual had knowledge of their regulatory responsibilities.

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

Engaging and involving people using the service, the public and staff, fully considering their equality Characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

• Regular updates were sent to staff on a computer system to their devises for quick communication and to provide any updates or changes within the service.
• Although we saw evidence of survey's beings completed with people there were only 38 responses from February 2021 to August 2021. All but two people and relatives we spoke with said they had not been asked to give feedback about the service.
• Most people and their relatives said they knew how to communicate with the service when needed.
• Staff said they were able to raise concerns with the management team when required. However, some staff said feedback following concerns raised had not always been fed back to them.
• People and relatives told us they felt well supported by most staff that visited their homes.

Working in partnership with others

• The provider worked effectively and in partnership with the local authority.
• The nominated individual told us they had experienced difficulties receiving up to date information from general practitioners about people's updated medication prescriptions. The service did not regularly contact health professionals to obtain updates. For example, warfarin clinics had not been contacted to check people's dosages were correct.

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 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to ensure proper and safe management of medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was failure to follow systems in place to assess, monitor and improve the quality and safety of the service provided. There was a failure to maintain accurate and complete records.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not taken appropriate steps to ensure staffing levels were sufficient. Staff had not completed all of their training and supervisions were not carried out on a regular basis.