Brunelcare

Brunelcare Domiciliary Care Services Bristol & South Gloucestershire

Inspection report

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13 September 2018
14 September 2018

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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

This inspection took place between 11 and 14 September 2018 and was announced. We gave the service 48 hours' notice of the start of our inspection because we wanted key people to be available. Inspection site visit activity started on the 11 September 2018 and completed the following day. Telephone calls to people who used the service were made on the four days, 11 to 14 September 2018.

There was a registered manager in post and they were available when this inspection took place. 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.

The last inspection of the service was completed in February 2016 and we rated the service overall as Good. There were no breaches of the regulations.

In April 2018 the service became one of four preferred domiciliary care providers for South Gloucestershire Council. The geographical area covered by this service include Kingswood, Downend, Emersons Green, Pucklechurch, Wick, Marshfield, Hanham, Longwell Green, Cadbury Heath, Oldland Common and Barrs Court. The service has two functions. To provide a six-week reablement service to help people regain as much independence as possible and a long-term community care service.

People were safe. Staff completed safeguarding adults and moving and handling training to ensure they maintained people's safety. Risk assessments were completed as part of the care planning process. Where risks were identified there were plans in place to reduce or eliminate the risk. Safe staff recruitment procedures were followed to ensure people were not looked after by unsuitable staff. There was a staff recruitment drive in place to ensure there were sufficient numbers of staff to fulfil their commitments and in the meantime care calls were sub-contracted to agency workers. Medicines were managed safely.

The service was effective. Staff received training to enable them to carry out their jobs well. New staff completed an induction training programme at the start of their employment and any new-to-care staff completed the Care Certificate. There was a mandatory training programme for all staff to complete to ensure they had the necessary skills and knowledge to care for people correctly.

People's care and support needs were assessed and a support plan devised detailing how the service would support them. For those people who were supported by the reablement team, their goals were identified and their care plan set out how the staff would help them regain as much independence as possible. People were provided with assistance to eat and drink well where this had been identified as a care need. The staff, particularly the reablement workers, worked with other health and social care professionals to ensure people's health and wellbeing was maintained.

People were encouraged to be as independent as possible and were involved in making decisions and making their own choices about their care and support. People were asked to consent before care and support was delivered. The service was meeting the requirements of the Mental Capacity Act 2005.

The service was caring. People were treated with kindness and were listened to. The service had come through a period of upheaval and people had not liked the lack of continuity with the staff who covered their care calls. There was an acknowledgement that things were settling down and the staff were now able to form good working relationships with the people they were looking after.

The service was responsive. Care plans and the service delivery arrangements were reviewed after six weeks and then annually or more often if needed. Care arrangments were amended as required. People were provided with information about the service and details about how to raise any concerns they may have. People were encouraged to provide feedback about the service they received and action was taken where necessary.

The service was well led. The staff team was led by a registered manager. The two staff teams were provided with good leadership and management. Staff meetings ensured they were kept up to date with changes and developments in the service. There was a regular programme of audits in place, which ensured that the quality and safety of the service was monitored.

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

Brunelcare Domiciliary Care Services Bristol & South Gloucestershire

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 was 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 was announced and was undertaken by two adult social care inspectors and an expert by experience. We gave the service 48 hours' notice of the start of our inspection because we wanted key people to be available.

Prior to the inspection, we looked at the information we had received about the service since the last inspection in April 2016. This included notifications that had been submitted by the service. Notifications are information about specific important events the service is legally required to report to us. We also looked at the Provider Information Return (PIR) the service had submitted to us in April 2017. The PIR was information given to us by the provider. This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make.

During our inspection we spoke with 34 people who used Brunelcare services and three relatives. We spoke with the registered manager and the operations manager, team leaders, admin support, community care staff and reablement workers. We received feedback from two health and social care professionals and their comments have been included in the main body of the report.

We looked at care documents, staff files including training and supervision records, key policies and procedures, completed audits and other records related to the running of the service.

Good

Is the service safe?

Our findings

The service remains safe. People said, "I feel safe with the staff", "I have always felt safe when the staff are in my home", "I feel a lot safer when I know I have got someone (member of staff) who has been to me before" and "I have never not been treated nicely, all of the carers are very friendly".

All community care staff and reablement workers completed safeguarding, moving and handling and health and safety training as part of the provider's mandatory training programme. This meant they were trained how to look after people safely and knew what action to take if abuse was suspected, witnessed or a person made an allegation of harm. The provider's safeguarding policy was displayed in office. Staff said they would report any concerns they had to the registered manager or any of the team leaders but knew they could report directly to the local authority, the Police and CQC. The service had appropriately raised safeguarding alerts with the local authority in the last year where the safety of people was a concern.

A number of different risk assessments were completed for each person who used the service. They were completed in respect of any particular activities the person may take part in, the management of medicines and other health care needs. Risk assessments were undertaken of the person's living environment to ensure the safety of the person and community care staff or reablement workers who were supporting them. A moving and handling risk assessment was undertaken where staff needed to assist people to move or transfer from one place to another. Their care plan set out the equipment to be used and the number of staff required. During the first and subsequent care plan reviews risk assessments were revisited and updated as necessary. This ensured risks were managed and minimised.

When people were supported by both community care staff and reablement workers and needed assistance with shopping tasks, the provider had a 'managing financial transactions on behalf of customers' policy. All support with shopping transactions was recorded and receipted.

All staff received infection control training and were supplied with personal protective equipment (gloves, aprons and hand sanitising gels).

In April 2018 the service had become one of South Gloucestershire Council's preferred domiciliary care providers covering two of their geographical areas. At this time a significant number of care providers had transferred people who used their services and staff to Brunelcare. However insufficient community care staff had transferred and they have needed to sub-contract with other care agencies to cover care calls. The change had caused a great deal of upheaval for the service but their actions to improve this situation had now minimised the impact upon people using the service and the staff team. The service was reducing both the numbers of agencies they sub-contracted with and the number of hours per week.

All staff were employed for contracted hours unless they wanted to work on a 'bank basis' and a zero hours contract. This flexibility enabled the service to meet increased demand. Additional community care staff had already been recruited but there was an ongoing programme of recruitment in place. The service had planned to participate in a radio campaign and had arranged for leaflet distribution regarding taking on

new staff.

The service followed safe recruitment procedures to ensure only suitable workers were employed to work with the people they supported. Pre-employment checks were undertaken and included an interview and interview assessment, written references from previous employers and a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check whether the applicant had any past convictions that may prevent them from working with vulnerable people. The file for one member of staff we checked was missing written references however these had been located by day two.

Where people needed support with their medicines the level of support they required was assessed and detailed in their care plan. Community care staff and reablement workers were trained to administer medicines safely and their competency was rechecked regularly. Medicine charts were completed following administration and these charts were returned to the office monthly. The registered manager explained that the auditing of these charts should have been completed but had slipped. There was a plan in place to reintroduce these checks to ensure the charts had been filled out correctly and signed by the staff member. The service had two dedicated 'medicine champions' who were able to support the rest of the staff team with any questions regarding medicines.

Good

Is the service effective?

Our findings

We asked if the service was effective . A lot of the negative comments we received were in respect of the number of different care staff who attended their care calls, calls being covered by 'agency staff' and the timings of calls not being ideal. There was recognition however that things had now settled and people were happier with the service they received. Positive comments were made by others in respect of being 'cared for by a male carer as requested, the care staff providing support in exactly the way they wanted and always being asked for permission before care and support was delivered'.

For people who were to receive support from the community care staff a full assessment of their care and support needs was undertaken by the 'visiting officer'/team leader. The information gathered ensured a person-centred approach to planning their care. Care plans were written and agreed with the person and a brief summary of key details in the care plans were shared with the community care staff electronically. Where people's care and support service was commissioned by the local authority, a copy of the assessment and care plan was kept with the person's other care records.

The assessments for people who received a reablement service were completed by the reablement team leader or a senior reablement worker. A 'meet and greet' visit was made upon discharge from hospital or at the start of the service and goals were set to be achieved during the six weeks of support.

All staff were well trained in order to do their jobs well and effectively. The provider had an induction programme for all new staff, some for corporate information and also other role-relevant training. Records and conversations with staff evidenced they had completed induction training. Any new-to-care staff completed Care Certificate training which prepared adult social care workers for their role. New members of staff in both the community care team and the reablement team would shadow with other experienced members of staff for a minimum of three shifts, until they were confident to visit people on their own.

Existing staff completed mandatory update training. This included moving and handling training, safeguarding and the Mental Capacity Act 2005 (MCA). Those staff who had been transferred from other care providers were expected to complete all the mandatory training in their first six months, even if they had worked in social care for many years. This was to ensure that a basic level of training was completed. Person specific training was arranged as necessary and examples included dementia care, Parkinson's, monitoring health, stoma and catheter care and mental health. The measures the provider had in place ensured staff had the skills and competencies appropriate to their role.

Staff were encouraged to complete health and social care diplomas at level two or three. The registered manager had completed a level five diploma in social care and planned to do a further level five qualification in leadership and management.

All staff were expected to attend a regular supervision session with their line manager however the arrangments had slipped for many of the staff team since April 2018. The supervision could be in the form of a face to face meeting with their team leader or a spot check of work performance whilst fulfilling their job

role. All of the community care staff and reablement workers we spoke with had recently had a supervision meeting and said they were well supported. The registered manager was aware of this shortfall and already had plans in place to ensure all staff were supervised every three months and had an annual appraisal. In addition, the staff team were supported by regular team meetings and had access to a confidential helpline where they could get well-being, emotional, legal and financial advice.

There were on-call arrangments in place out of office hours and this was shared by the team leaders and senior staff members. The office was open seven days a week, manned by a rota of team leaders and senior community care and senior reablement workers.

People were supported with meals and drinks where this had been assessed as part of their care plan. Where people were at risk of malnutrition or dehydration, this was recorded in their care plan and the community care staff kept an eye of them. Any concerns would be reported to the senior staff and health care professionals.

Each person was registered with their own family doctor and community care staff would support a person if they needed to make arrangments to see them or were worried about any health care matter. In addition, the reablement workers had close working relationships with health and social care professionals such as occupational therapists, physiotherapist, the district nurses and social workers. Feedback from social care professionals was positive. One said, "Brunelcare is one of the most reliable and well-respected care provider".

Staff were aware of the need to ask for people's consent and people told us the staff always asked if it was alright for them to assist and support them. People were encouraged to say how they wanted to be looked after and any preferences they had were respected. Where people had dementia or cognitive impairment they were still asked to give agreement before being assisted. Staff told us if they had concerns regarding and person who was declining assistance or making unwise decisions they would report to a team leader. Staff were aware of the principles of the Mental Capacity Act 2005 (MCA).

Good

Is the service caring?

Our findings

People told us the community care staff and the reablement workers were kind, caring and very helpful. They said, "They are absolutely wonderful. The care is brilliant. I never feel embarrassed with them, they make sure you feel dignified", "The girls are great. I can't speak highly enough about them" and "I am happy with the staff, they are very caring". We did receive negative feedback from most people and the relatives we spoke to, about the lack of consistency in the care staff (community care team) who visited them. There was acknowledgement from people that this was an improving picture. The registered manager explained there had been a focused effort from the community care team leaders to review the work rotas and get back to ensuring people were supported by the least number of community care staff. Reablement workers worked four on/four off shifts therefore people who were supported for six weeks received care calls from minimal staff.

All the community care staff and reablement workers we spoke with were knowledgeable about the people they were supporting. They said they would recommend the service to their friends and family either as a 'service user' or to work for the community or reablement teams.

All staff completed equality, diversity and inclusion training and this covered dignity and respect. The service ensured people were always treated with kindness. Workplace supervisions were undertaken so senior staff could monitor work performance and make sure people were treated as individuals with their own specific care and support needs.

People confirmed they were always included in discussions about their care and support. They said they were encouraged to express their views and make decisions for themselves. People's preferences, likes and dislikes were always respected. They were asked by what name they preferred to be called and any preferences regarding the gender of the staff that supported them. People were asked about their life history so that the care and support staff could have meaningful conversations with them.

The service had received a significant number of thank you cards and letters from people who had received a reablement service or long-term support. Comments from people were displayed in the office and staff were informed whenever specific feedback had been received about them.

Good

Is the service responsive?

Our findings

We received a mixed response from people about the service they received. Many of the comments were around the timings of the care calls. One person said their care calls were provided at times "they think I need rather than the times I originally asked for" and another said, "I never know who is coming or what time they will get to me". A lot of the comments were made about the number of carers who visited people, and the inconsistency but there was recognition this had improved recently. Since the service had become one of the preferred domiciliary care providers in April 2018 and over the summer holiday period this had been a significant problem but the service had already worked hard to improve their planning. Not all comments were negative. Others said, "They are doing everything I wanted originally and is detailed in the care plan", "I would happily say I am getting the care how I like it", "They always get to me, sometimes they are running late but they do ring me to let me know and it is not a problem for me" and "My carer is very responsive to my particular needs".

People had a care file in their homes and these contained a paper copy of their care plan, information about the service, the out-of-hours contact details and the complaints procedure. Information about the service was produced in written format but could be provided in other formats as necessary.

In the care office, copies of the care plans were kept electronically and in paper form. People's care plans detailed the person's medical history and any allergies, details about their life, their preferences and things that were important to them. The 'daily' support plan set out the days, times of day and lengths of each visit. Risk assessments were completed in respect of moving and handling tasks and an assessment made where support was required with medicines. The care and support plans were reviewed six weeks after the start of a service and then annually. In between support plans could be adjusted as and when necessary. Community care staff were expected to report back to their team leader any changes in a person's care and support needs. Reablement workers were able to make amendments to the service provided based on an increased independence or a deterioration in abilities. This meant people would continue to receive the care and support they needed and took account of any changes.

People were encouraged to raise any concerns they had or were unhappy about any aspects of their care. They were able to do this when their care and support plan was being reviewed, when senior staff/team leaders visited their home to monitor staff performance, or during telephone review calls. The provider had a complaints policy and procedure and a copy of this was kept in each person's care file in their homes. We discussed with the registered manager how one specific complaint had been handled. The family of a person who received a service was unhappy with the consistency and competency of some care staff who attended. Records evidenced the actions taken and how the complainant was satisfied with the outcome.

The service continued looking after people when they were unwell, very poorly or at the end of their life. They worked alongside people's family and friends, and health and social care professionals where appropriate.

Good

Is the service well-led?

Our findings

People and relatives told us the service was now better organised after a significant period of upheaval between April and August 2018. They said things had now settled down, they were getting the same staff regularly, timing of calls had improved and they were receiving information about work rotas. One social care professional said the service was one of the most reliable and well-respected care providers who had worked well with them following new commissioning arrangments that had been put in place in April.

Both the community care teams and the reablement team were led by the registered manager who had been in post since October 2016. The registered manager was well qualified and had completed a management development programme with Brunelcare. The registered manager was supported by six team leaders, administration staff and area and operational managers. The registered manager held weekly team meetings and team leaders held meetings with their staff groups. Staff were encouraged to share their thoughts and opinions and any improvements they felt would enhance people's lives or their working time.

People who used the reablement service were asked to give feedback after three weeks of using the service. They were asked to provide feedback about the service received, the staff, communication and any improvements they suggested. This used to be completed at the end of the six week 'reablement' period however did not enable the service to act upon the feedback. People who received a service from the community care team were asked to complete survey forms and provide feedback. The registered manager explained that the response rate to written surveys was generally poor therefore they had increased the number of telephone reviews they completed. The collated survey results for the end of 2017 had been generally positive.

The provider had a range of quality assurance and auditing systems in place to monitor the quality and safety of the service. Their own senior management team completed overall audits of the whole service (like a mini CQC inspection) and these resulted in action plans where shortfalls were identified. The registered manager had to complete a set of audits each month and submit these to their line manager. In August 2018 audits had been completed in respect of compliance with staff using the electronic call monitoring system and punctuality of care calls. These are just two examples of how the provider ensures the service is well-run and well-led.

The provider had a full range of policies and procedures and these were regularly reviewed. The key policies we looked at were the handling complaints policy, equality and diversity policy, the medication policy and the safeguarding policy. The registered manager said the task for reviewing and updating policies was shared between managers who were each allocated two or three at a time. Staff we spoke with knew how to access the policies if they needed advice and guidance.

The registered manager knew when notifications had to be submitted to us. Notifications were about events that had happened in the service and included any accidents, incidents or safeguarding concerns for example. The registered manager also reported any of these events through their internal reporting systems. Following any events, the service looked for any lessons to be learnt to prevent or reduce the

chance of a reoccurrence. One example was the introduction of a 'concern pack' in each person's care file. This pack contained a concern/issues log, a body map, a food and fluid chart, skin integrity assessment forms and a district nurse contact form. This had been introduced after concerns had previously been raised when care staff had not acted when a person's health had deteriorated. The registered manager talked about the need for the service to drive forward with improvements to benefit people.

The registered manager and other senior managers liaised with other relevant organisations to support care provision and service development in the area. The registered manager attended network meetings with Care & Support West three or four times a year. The most recent meeting had been about meeting the CQC requirements of a well-led service. The meetings were also an opportunity to share ideas of best practice and discuss frustrations, for example staff retention.