Border Cottage Care Limited

Border Cottage Care

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 12 October 2016 and was announced. The provider was given notice because the location provides domiciliary care services and we need to be sure that someone would be in. A second day of inspection took place on 21 October 2016 and was announced.

Border Cottage Care is a domiciliary care service which provides personal care to people within their own homes who have a variety of needs, including physical disabilities, sensory impairment, mental health, dementia and learning disabilities. Care is provided to older people and also young adults. The registered provider's office is based in Castleford and provides are and support to people in surrounding areas. At the time of this inspection there were 90 people who used the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered provider's, they are 'registered persons'. Registered person's have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were systems and processes in place to protect people from the risk of harm. Staff were able to tell us about the different types of abuse and what actions they would take if they suspected abuse was taking place. No safeguarding alerts had been made but the registered provider was knowledgeable about when an alert would need to be raised.

Risk assessments were in place for people who needed them and were specific to people's needs. These had been regularly reviewed and updated when required.

Robust recruitment procedures were in place and appropriate checks had been made before employment commenced. New staff attended a thorough induction process including shadowing an experienced member of staff before working in the community.

The service had policies and procedures in place to ensure medicines were managed safely. Accurate records were kept to show when medicines had been administered, the use of topical medicines was not always recorded.

Staff performance was monitored and recorded through a system of regular supervisions and appraisals. Staff had received up to date training to support them to carry out their roles safely. Staff demonstrated good knowledge and understanding of the requirements of the Mental Capacity Act 2005.

Where appropriate, staff supported people to enjoy a good diet and suitable food and nutrition which was reported in daily visit reports. People were supported to maintain good health and had access to healthcare professionals and services when needed.

People and relatives were actively involved in care planning and decision making, which was evident in signed care plans. Information on advocacy services was available.

People spoke highly of the service and the staff. They were treated with dignity and respect.

Care plans detailed people's needs, wishes and preferences and were person centred which meant they received personalised support. Care plans had been reviewed and updated when required.

The service had a clear process for handling complaints. There had been four recorded complaints made to the registered provider in the past 12 months. These had been investigated in line with the registered provider's policy and we could see appropriate action had been taken by the registered manager.

Staff described a positive culture that focused on the people using the service. They felt supported by the management. Staff told us that all managers were approachable and they felt confident that they would deal with any issues raised.

Staff were kept informed about the operation of the service through regular staff meetings. They were given the opportunity to recognise and suggest areas for improvement.

Quality assurance processes were in place and completed by the registered manager and operations manager. The registered providers also visited the service regularly to monitor the quality of the service although these visits were not always recorded.

Accidents and incidents were fully recorded and appropriate actions were taken to reduce the risks.

The registered manager understood their role and responsibilities. Notifications had been submitted to CQC in a timely manner.

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.

There were systems and processes in place to protect people from the risk of harm. Staff were able to tell us about the different types of abuse and what actions they would take if they suspected abuse was taking place.

Up to date risk assessments were in place for people who needed them and were specific to people's needs.

Policies and procedures were in place to ensure medicines were managed safely. Accurate records were kept to show when medicines had been administered.

Robust recruitment procedures were in place and appropriate checks had been made before employment commenced.

Is the service effective?

Good

The service was effective.

Staff demonstrated good knowledge and understanding of the requirements of the Mental Capacity Act 2005.

Staff performance was monitored and recorded through a system of regular supervisions and appraisals.

Staff had received up to date training to support them to carry out their roles safely.

People were supported to maintain good health and had access to healthcare professionals and services when needed.

Is the service caring?

Good

The service was caring.

People spoke highly of the service and the staff. People said they were treated with dignity and respect.

Staff were knowledgeable about the likes, dislikes and

preferences of people who used the service.

Care and support was individualised to meet people's needs.

Is the service responsive?

Good

The service was responsive.

People, and where appropriate their relatives, were actively involved in care planning and decision making.

Care plans detailed people's needs, wishes and preferences and showed they received personalised support.

The service had a clear process for handling complaints. People we spoke with knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

A long standing and competent registered manager was in place.

Quality assurance processes were in place and regularly carried out to monitor the quality of the service.

Feedback from people who used the service and relatives was sought.

Regular staff meetings had taken place and staff told us they were supported by the registered provider.

Border Cottage Care

Detailed findings

Background to this inspection

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

This inspection took place on 12 October 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. The second day of inspection took place on 21 October 2016 and was also announced.

The inspection team consisted of one adult social care inspector.

Before the inspection we reviewed all the information we held about the service, which included recent notifications submitted to the Care Quality Commission (CQC). The registered provider had completed and submitted a provider information return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and what improvements they plan to make. We used this information to plan our inspection.

During the inspection we reviewed a range of records. This included four people's care records and five people's medicine administration records. We also looked at four staff files which included their recruitment, supervision and appraisal records. We looked at five staff records relating to training. We also looked at records relating to the management of the service and a variety of policies and procedures.

We spoke with eight members of staff including the registered manager, training manager, operations manager, two supervisors and three care staff. We also spoke with four people who used the service.

Good

Is the service safe?

Our findings

People told us they felt safe using the service. One person said, "Of course we feel safe with them. I see the same faces." Another said, "Yes I feel safe – my carers are regular and reliable and that's what matters to me. They are excellent and very efficient at what they do."

We looked at the arrangements for managing risks to ensure people were protected from harm. Risks to people were assessed and care plans put in place to reduce the possibility of them occurring. Where a risk was identified, further assessment took place to assist in taking remedial action. For example, one person required assistance with showering. The care plan detailed that this person could manage most tasks but required re-assurance and the presence of a carer made this person 'feel safer'. A risk assessment had been developed and identified areas of risks and how these could be reduced such as 'person struggled to wash legs so support was to be given in this area'.

We looked at arrangements in place for managing accidents and incidents and what actions were taken to prevent the risk of re-occurrence. Appropriate forms were completed for each accident or incident that had occurred. Blank accident and incident forms were also available in people's care plans so staff had access when they needed them. We spoke to the registered manager who was able to tell us what action they would take if any person experienced regular accidents, for example making referrals to other professionals such as the falls team.

All staff spoken with had a good level of knowledge and understanding of safeguarding and the different types of abuse. They were able to tell us the procedure they would follow should they suspect abuse. An up to date safeguarding policy was available. We looked at the staff training records in relation to safeguarding. We could see that all staff had received training in safeguarding.

Staff told us they would not hesitate to whistle-blow (tell someone) regarding any concerns they had. One member of staff said, "I would do what I had to do. I would not hesitate. I know the manager would be supportive and it is my job to keep people safe."

Systems were in place for the safe management of medicines. A medicine policy gave guidance to staff on their roles and responsibilities for managing medicines safely, on handling 'as and when required' medicines and on reporting concerns. Each person's care file contained a list of their medicine and the level of support they needed to administer them, and these ranged from self-medicating to staff administering them. Staff had their competencies with regards to administering medicine monitored on a regular basis and this was recorded.

People's use of medicines was recorded using a medicine administration record (MAR). A MAR is a document showing details of the medicines a person has been prescribed and records when they have been administered to them. We looked at five people's MARs and saw there were no gaps in administration. Where medicines had not been administered the reason for this had been recorded. However, MARs used for recording the administration of topical medicine were not always completed fully. For example, we could

see there were gaps in recordings of when topical medicine had been applied and insufficient details as to the area of the body the topical medicine was to be applied to. We spoke with the registered manager about this. One the second day of inspection action had been taken to improve recordings and additional 'body maps' for topical medicine had been introduced.

People we spoke with told us they were supported by a regular team of staff and were kept informed about any changes that needed to be made to the staffing arrangements. One person said, "I have my own team of carers who know me well. My rota is pretty much the same every week." Another person told us, "We might get someone else if the regular carer is on holiday but we are always told in advance." Rotas were produced up to four weeks in advance. Staff were allocated 'runs' of calls which were the same each day. The 'runs' of calls were allocated by area to reduce travel time needed. All staff worked full days and for each 'run' there was two staff allocated who worked back to back, one member of staff covering three day and one member of staff covering four days each week. This meant that there was consistency with the care that was provided.

We asked the registered manager how they determined staffing levels. They told us they only accepted new care packages if they were sure they had capacity to manage them appropriately. The registered manager told us, "We are very different to most care providers. Our staff have set rotas and work full days so we can offer consistency. We have three peripatetic care staff who can provide cover should a member of staff leave the service. This allows us time to recruit new staff when required." The three peripatetic members of staff also provided support to cover holidays and sickness. This meant that the registered provider had procedures in place to ensure there was enough staff to appropriately support people.

The registered provider operated an 'on call' service for outside of normal working hours so people who used the service could contact Border Cottage Care in the event of an emergency, for example a member of staff not arriving for scheduled visit. This was managed by the operations manager and two supervisors on a rota system. Records we looked at confirmed that calls made to the on call service were recorded and appropriate action had been taken when needed.

During the inspection we looked at four staff recruitment files. We could see from the records we looked at that safe recruitment procedures were followed. Applications and interviews had been completed. Two checked references, where possible, from a current employer, and a Disclosure and Barring Service (DBS) check had been sought prior to staff starting employment. The Disclosure and Barring Service carry out criminal records and barring checks on individuals who intend to work with vulnerable adults. This helps employers make safer recruitment decisions and also minimise the risk of unsuitable people working with vulnerable adults. Recruitment files also contained photographic identification and proof of identity.

Good

Is the service effective?

Our findings

We asked staff to tell us about their induction, training and development opportunities they had been given at the service. Staff told us, "I did a lot of training before I went out into the community with another staff member. I got to meet the people I would be looking after first too. I've always had support." Another staff member told us, "We are regularly asked to attend training, sometimes to refresh but sometimes it might be a new course. We have the opportunity to do higher qualifications as well".

New staff had completed induction training before they worked alone. This included 'shadowing' an experienced staff member in the community and gaining knowledge of people's routines, likes and dislikes. When staff had completed induction training they had a 'probation review' meeting with the registered manager to assess whether further training was needed and whether they wished to receive extra support in any areas. This meant that new staff received the support and training they needed to effectively support people.

We spoke to the registered manager about training who told us, "Staff complete a thorough induction process before they work in the community. We do face to face training. Some training just can't be delivered online and you need hands on practice, for example moving and handling training. We have an in-house trainer who is qualified to deliver the training that we need."

We looked at training records for five staff which confirmed that mandatory training for staff was up to date. Mandatory training included safeguarding, moving and handling, infection control, first aid and medicines management. Mandatory training is training the registered provider thinks is necessary to support people safely. Training in specialist areas had also been provided to a large number of staff in areas which included PEG feeding via a tube.

People we spoke with told us they thought staff were suitably trained to look after them. One person said, "They seem fine to me. I have no concerns. They all know what they are doing." and "I know they all get training, I don't have any grumbles about them."

Staff were supported with regular supervision and appraisal. Supervision is a process, usually a meeting, by which an organisation providers guidance and support to staff. From the records we looked at, we could see that these meetings were used to discuss and provide support for needs that staff members had, as well as confirming their knowledge and performance over a period of time. Records confirmed regular supervisions and appraisals were taking place. The registered provider also conducted 'spot checks' on staff. Spot checks were used to assess the staff member in the community whilst providing care and support to people. Staff had received up to four spot checks in a 12 month period.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 capacity to make particular decisions, any made on their behalf must be in their best interests and 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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS), but these do not apply to people living in their own homes.

We checked whether the registered provider was working within the principles of the Mental Capacity Act 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We asked the registered manager what training staff received in MCA. They told us that this was covered in the induction process and were able to provided evidence of this.

The staff we spoke with had a good understanding of the principles of the MCA and were able to explain what action they would take if they suspected a person lacked capacity. The operations manager told us, "All staff understand the principles of the MCA and I am confident they would speak to a member of the management team if they had any concerns over a person's capacity."

Care plans recorded people's consent to support and details of any assessments that had been undertaken. We could see consent to care had been given by people or, where appropriate, their relatives, and signed documentation was present in care plans to evidence this. These documents covered areas such as consent to care and treatment, sharing information, key holding and medicine being administered to people.

Some people received support with food and nutrition as part of their care package. One person said, "They do help me prepare food and snacks. I always choose what I want." Staff were able to describe how they worked with others to support people in this area. For example, one person was fed using a percutaneous endoscopic gastrostomy (PEG). A PEG is a tube which is passed into a person's stomach, most commonly to provide a means of feeding when oral intake is not adequate. A detailed plan of the required feeds was available in the care plan and recorded on the person's MAR. We could see that staff had accurately recorded and feeds that had been given. Training had been provided to all staff who were supporting people with a PEG.

The operations manager was able to tell us who they would contact if they had concerns regarding nutrition, such as a dietician or speech and language therapy (SALT). SALT provides treatment, support and care for children and adults who have difficulties with communication, or with eating, drinking and swallowing. Care plans contained details of people's dietary preferences and any specific dietary needs they had, for example, whether they were diabetic or had any allergies. We looked at people's 'daily visit reports' which staff completed after each visit. These detailed what the person had chosen to eat and we could see that a variety of food was prepared and offered to people. This meant people were supported with food and nutrition where necessary.

Care records contained evidence of close working relationships with other professionals to maintain and promote people's health. These included GP's, district nurses and dieticians. We could see that referrals to these professionals had been made in a timely manner and these visits were recorded in people's 'daily visit reports'.

Good

Is the service caring?

Our findings

People who used the service told us they were happy and staff were caring. One person said, "They are excellent, all of them. I think they provide super quality." Another person told us, "They are absolutely fine. I have had them for 12 months or so and never had a problem. I say what I want and they do it. What more could you want."

Staff were able to explain to us how they respected a person's privacy and dignity, by keeping curtains and doors closed when assisting people with personal care and by respecting people's choice and the decisions they made. One staff member told us, "I never just walk into a person's home. I always knock, wait a second and then open the door and announce who I am. I always wait for them to say come in before I go any further."

Care plans detailed people's preferences around the care and treatment that was provided. We could see evidence, such as signatures, that relatives had been involved in care planning and in some situations correspondence from relatives via email and letter recording their views. We saw evidence in care plans that relatives were regularly invited to care plan review meetings. Relatives we spoke with confirmed they were involved in care planning and kept updated. Some relatives had helped staff to create a person centred way of providing care to their relatives and this was displayed within the care plans. For example, one relative had provided a step by step guide on how best to support the person with personal care.

It was evident from discussions with the registered manager that staff knew people well, including their personal history, preferences and likes and dislikes. People were able to choose a time for staff to visit and the registered manager told us they tried to accommodate everyone's preferences. We could see when people had requested a change in the time of a visit that this had been accommodated.

The supervisors regularly visited people who used the service to allow people to express their views on the service being provided. For example, one person had requested that staff help them to learn to write as this was something they had struggled with throughout life. The supervisor had communicated with the person's relatives and 'learn to write' books had been purchased. Discussion with staff had also taken place to explain how they could support the person to accomplish their wishes. The supervisor had re-visited the person the following week to monitor the progress and recorded that the person had managed to write 'half a page with support from [staff]'. These discussion were recorded and signed by people, and where relevant, relatives.

At the time of inspection no-one using the service was using an advocate. Advocates help to ensure that people's views and preferences are heard. The registered manager told us that they could be arranged for people who wished to have one, and was able to explain how this would be done.

Good

Is the service responsive?

Our findings

During the inspection we looked at four care plans. Care plans contained details of what was important to the person and how they wished to be supported. This gave staff a step by step guide of how to support the person in areas such as person care and moving and positioning. The operations manager was in the process of developing a 'This is me' document for each person that used the service. The operations manager was able to show us what had been produced and included information such as 'people that are important to me, things I enjoy, things I don't like and places I have been in my life'.

Care plans were person-centred and produced to meet individuals' support needs in areas such as personal care, communication, mobility, nutrition and sociability. They were detailed and focused on people's preferences and were reviewed on a regular basis. For example, one care plan detailed how a person liked to wash themselves independently but required care staff to wash and dry their back and legs. Also, how they liked a cup of coffee on a morning with two flat spoons of sugar and a dash of milk. Another care plan detailed that one pillow should be placed behind a person's shoulder, one pillow under their right arm and two pillows under their left arm to make them comfortable. This meant people were receiving care in a way they wished to be supported.

We spoke to the registered manager about how they ensured they could meet a person's needs before a new care package commenced. The registered manager told us that a meeting was arranged between the person who was enquiring about the care and the operations manager. The operations manager asked a series of questions to ensure they could provide the support required and that they had staff available at the requested times. The register manager told us, "We won't just take on a package to make money. We make sure we can meet the person's needs and that it won't have an impact on the other people we already provide support to."

We spoke with staff who were extremely knowledgeable about the care that people received. They told us that they had a regular rota and visited the same people on a daily basis. They were able to give details of how they delivered personalised care. One staff member told us, "We build relationships with people. When you visit them every day you know what they like and what they don't and it is recorded in their care plan." Another staff member told us, "Care plans have enough detail in to guide you but generally you know the needs of the person before you visit. People don't like to have strangers and that's why it is good here because we have the same rota almost all the time."

People who used the service told us that staff were familiar with their likes and dislikes and their care needs. One person said, "They all know what they are doing. They know me and I know them." Another person told us, "All the carers know me very well. They know what I like and what I don't like. Even the office staff seem to know my needs which is comforting to know."

Some of the people who used the service were supported by staff to access the community and participate in activities. When this was required, as part of the care package, a record of activities were available in the person's home and completed by staff after each visit. We looked at these records and could see people

were supported to enjoy a wide range of activities of their choice including baking, shopping, beauty treatments, gardening and walks in the community.

The registered provider had a complaints policy which people who used the service received in their 'customer guide'. This explained how complaints would be investigated, with relevant timescales explained. There had been four recorded complaints made to the registered provider in the past 12 months. These had been investigated in line with the registered provider's policy and we could see appropriate action had been taken by the registered manager. For example, one person had raised concerns that a person was not eating correctly. As a result a discussion took place with the person and a meal plan had been developed and was used by staff.

The registered provider had seven recorded compliments in the past 12 months. One said, "The staff have always been very punctual, attentive and very friendly" and "We are very lucky to have found this company." Other comments included "Members of Border Cottage Care have treated [relative] with love and respect and carried me through when I have found [relatives] illness difficult to manage" and "Your timekeeping, commitment and reliability have been beyond expectations. I feel so lucky." Positive feedback was shared with staff by management.

Good

Is the service well-led?

Our findings

People who used the service spoke positively about the registered manager. One person told us, "The management is very good. They have visited me and made me feel very confident about the care and staff. I can't see me ever wanting to go to another provider." Another person told us, "The management is great. Always at the end of the phone and will come out willingly if we ask. Nothing is too much trouble."

During our inspection we could see that the registered manager had an active role in the day to day running of the service. It was clear that they were knowledgeable about people who used the service and their care needs and was able to answer questions about them and their staff.

We asked staff about the management of the service. Staff said there was a positive culture and that they were supported by the registered manager. One staff member told us, "The manager is available whenever we need support or advice, I can't fault them." Another staff member told us, "I have always had support. [Registered manager] is always around and their door is always open. There is always a member of the management team here. You can always speak to someone when you need to."

Regular staff meetings had taken place with the most recent being in October 2016. The minutes of the meeting showed that staff had the opportunity to raise concerns and be involved in decisions about the service. Areas that were discussed included medicine, care plans, bonus schemes, training and updates to any policies that had taken place. The registered manager told us that they aimed to have three staff meetings annually where different topics would be discussed. We could see that these arranged meetings had been well attended by care staff and different times had been arranged to ensure all staff could attend. Weekly management meetings also took place and were attended by the registered manager, training manager and operations manager.

During the inspection, we looked at feedback that was sought from staff and people who used the service. Quality assurance questionnaires were completed every three months. The operations manager told us, "Whenever a review of care needs takes place we do a quality assurance questionnaire also to gain the views of the people we provide care to and to check people are happy with the service. We are aiming for the quality assurance questionnaires to be completed every six weeks but we haven't quite managed that yet. Interaction and feedback from the people we provide care to is very important to us." We looked at a sample of quality assurance questionnaires and could see that people had provided positive feedback about the service.

People and their relatives told us they were regularly asked for feedback about the service and the care they received. One person told us, "We always get asked if we are happy or have any concerns." Another person told us, "I am always asked if I am happy."

The registered manager carried out a number of quality assurance checks to monitor and improve the standards of the service. Quality assurance and governance processes are systems that help the registered provider to assess the safety and quality of their services, ensuring they provide people with good services

and meet the appropriate quality standards and legal obligations. Monthly audits were carried out in areas such as weekly allocations, care plans, MARs and daily visit reports. We could see that audits on financial transactions were taking place but these were not completed monthly and only audited once the financial transaction sheet had been filled with transactions. One of the financial transaction sheets we looked at contained three months' worth of recordings. We spoke to the registered manager about this who contacted us after the second day of inspection to inform the system had been changed and all financial transaction sheets were returned to the office for auditing on a weekly basis.

Where issues were identified by these audits, action plans were put in place to address them. For example, discussions with staff at staff meetings or additional training arranged.

Registered provider audits were taking place, however we noted that these were not always recorded. We were told that the registered provider used a system on the computer to generate weekly reports that showed information such as how many quality assurance visits had taken place, how many staff supervisions or spot checks had been completed and also showed the number of care hours provided and a breakdown of people's needs. The registered provider was able to print these reports for us to view on inspection.

Following the inspection the registered provided contacted us to inform that a new auditing tool had been developed and they would use this to record any completed registered provider audits completed.

The registered manager understood their role and responsibilities. We noted that all relevant notifications relating to the service had been submitted to the Care Quality Commission. Notifications are changes, events or incidents the registered provider is legally obliged to send us within the required timescales.