Baryen Health Care Ltd

Baryen Health Care HQ

Inspection report

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Date of inspection visit: 10 February 2015
Date of publication: 31/03/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

The inspection took place on 10 February 2015 with the provider being given short notice of the visit to the office in line with our current methodology for inspecting domiciliary care agencies. The agency was registered with the CQC in April 2014 so this was the first inspection of the service under the new registration.

Baryen Health Care is registered to provide personal care to people living in their own homes. The service aims to provide care and support to older and younger people with a variety needs. These include people living with dementia, mental health, misuse of drugs and alcohol and people with a learning or physical disability. Care and support was co-ordinated from the services office which is based near Doncaster town centre.

The service had a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At the time of our inspection the service was only supporting a small number of people so we spoke with everyone they were supporting to gain their experience of using the agency.

At our inspection of 10 February 2015, we found a breach of Regulation 21 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

We saw a structured recruitment process was in place to help make sure staff were suitable to work with vulnerable people; however this had not always been followed. We found appropriate checks had been undertaken for staff supporting people on a regular basis, but two of the four bank staff files we checked did not have two written references on file. The provider told us they would take immediate action to address this shortfall.

People using the service received their care and support from staff who visited them on a regular basis. Where necessary bank care workers filled in for permanent staff when they were on leave. People who used the service raised no concerns about how the service was staffed and confirmed they had the same regular staff.

People's needs had been assessed before their care package commenced and they told us they had been involved in formulating and updating their care plans. Care records we sampled identified people's needs, as well as any risks associated with their care. However, the information provided did not always give clear guidance to staff about their role in supporting the person or their preferences. People who were using the service told us staff were meeting their needs and delivering care as they preferred and we found staff were knowledgeable about the needs and preferences of the person they were supporting.

Where people needed assistance taking their medication this was administered in a timely way by staff who had been trained to carry out this role. People told us had received their medicines appropriately and raised no concerns. However, medication records lacked specific information about the medications administered by staff. The provider told us they would take immediate action to improve the recording of any medicines administered.

The requirements of the Mental Capacity Act 2005 (MCA) were in place to protect people who may not have the capacity to make decisions for themselves. The Mental Capacity Act 2005 sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected. This includes balancing autonomy and protection in relation to consent or refusal of care or treatment.

We found new staff had received a structured induction and essential training at the beginning of their employment. This had been followed by more specialist training to enhance their knowledge and skills. Staff told us they felt well supported. However, there were no records maintained to evidence that formal supervision sessions had taken place.

The company had a complaints policy which was provided to each person at the start of their care package. The provider told us they had not received any formal complaints, but we saw an appropriate system was in place to record the details and outcomes of concerns raised.

The provider had a system in place to enable people to share their opinion of the service provided and check if company polices were being followed. Due to the small number of people supported by the agency since it registered with CQC this had not been fully utilised, but people confirmed they were regularly consulted about the care provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

We found the company's recruitment process had not always been followed as the provider had not received two written references for every member of staff delivering care. This meant people could be put at risk.

Records were in place to monitor any specific areas where people were more at risk, such as how to move them safely, and explained what action staff needed to take to protect people. However, records did not always contain sufficient detail.

There were systems in place to reduce the risk of abuse and to assess and monitor potential risks to individual people.

Systems were in place to make sure people received their medication safely, which included all staff receiving medication training. However, medication records lacked information about the medications administered.

Is the service effective?

Good

The service was effective.

Staff had completed training in the Mental Capacity Act and understood how to support people whilst considering their best interest. Records demonstrated people's capacity to make decisions had been considered and staff would act in their best interest when necessary.

Staff had completed an induction and had access to a varied training programme that helped them meet the needs of the people they supported.

Where people required assistance preparing food staff had received food hygiene training to help make sure food was prepared safely.

Is the service caring?

Good

The service was caring.

Staff demonstrated a good awareness of how they should respect people's choices and ensure their privacy and dignity was maintained. People using the service told us staff respected their opinion and delivered care in an inclusive, caring manner.

People received a good quality of care from staff who understood the level of support they needed and delivered care and support accordingly.

Is the service responsive?

Good

The service was responsive.

Summary of findings

People had been encouraged to be involved in planning their care. Care plans provided information about people needs, but were not always individualised to reflected their abilities and preferences.

The service liaised with outside agencies to make sure people's changing needs were met and care was delivered on an individual basis.

There was a system in place to tell people how to make a complaint and how it would be managed.

Is the service well-led?

Requires Improvement

The service was well led.

There was a system in place to assess if the agency was operating correctly and people were satisfied with the service provided. This included surveys and audits. This had not been fully utilised due to the small number of people who had used the service, but people had been consulted with informally on a regular basis.

Staff were clear about their roles and responsibilities and had access to policies and procedures to inform and guide them. However, we found some policies, such as the recruitment policy, had not always been followed by the management team.

Baryen Health Care HQ

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 began with a visit to the services office which took place on 10 February 2015. The provider was given short notice of the visit in line with our current methodology for inspecting domiciliary care agencies. The inspection team consisted of an adult social care inspector.

The service was only supporting a small number of people; therefore we visited everyone being supported so they could share their opinion of how the service operated. We also spoke with the management team and the care staff who supported people using the service, this included bank staff who may be asked to provide care and support when permanent staff were not available.

Before the inspection we requested the provider complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well, and improvements they plan to make. The provider told us this was not completed as they had not received our request. We also obtained the views of service commissioners and social workers who had been involved in arranging care packages for people.

We looked at documentation relating to people who used the service and staff, as well as the management of the service. This included reviewing care records, staff rotas, the training matrix, staff files, medication records, policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt care and support was delivered in a safe way. One person said, "She [the care worker] looks after me well, yes I feel totally safe."

Staff comments indicated that a satisfactory recruitment and selection process was in place. This included completing an application form, a face to face interview, two written references, (one being from their previous employer), and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. However, this was not confirmed in the recruitment records we sampled.

We checked five staff files and found appropriate checks had been undertaken for staff supporting people on a regular bases. However, although DBS checks had been carried out for all staff two of the four bank staff files we checked did not have two written references on file, as required in the provider's recruitment policy. In one file the checklist at the front stated one reference had been received, but it was not on file. We asked the registered manager about the lack of references, but they could not offer any explanation as to why references had not been obtained prior to staff commencing work.

This was a breach of Regulation 21 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager told us there were enough staff employed to meet the needs of the people being supported by the agency. One person we spoke with confirmed they had the same care worker all the time, with bank care workers filling in when they were on leave. They told us how the agency let them 'choose' their care worker and described how when one particular care worker who "Didn't suit" had been replaced.

Care staff we spoke with said they felt there was enough staff to meet the needs of the people currently being supported. We found systems were in place to respond to unexpected circumstances, for example to cover new care packages, sickness, absences and emergencies. The registered manager told us that due to the flexibility of the packages they took on they employed bank staff who could be called upon should additional cover be needed.

Policies and procedures were available regarding keeping people safe from abuse and reporting any incidents appropriately. The registered manager was aware of the local authority's safeguarding adult's procedures which aimed to make sure incidents were reported and investigated appropriately. Records showed that when concerns had been reported the provider had looked into the issues and taken appropriate action.

Staff we spoke with demonstrated a satisfactory knowledge of safeguarding people and could identify the types and signs of abuse, as well as knowing what to do if they had any concerns. They told us they had received initial training in this subject during their induction period or had already completed the training at another employment. This was confirmed in the training records we sampled. We saw there was also a whistleblowing policy which told staff how they could raise concerns about any unsafe practice.

Records were in place to monitor any specific areas where people were more at risk, such as how to move them safely, and explained what action staff needed to take to protect people. However, risk assessments did not always contain sufficient detail about how people should be supported. For example in one file we looked at the manual handling risk assessment said the person used a bath hoist to get in and out of the bath, but there was no guidance to tell staff how to do this safely. A care worker who supported the person described how this was carried out and confirmed they had received training in how to manually handle people safely. However, the lack of detail in the care plan and risk assessment could put people at risk if new staff were providing care. The person using the service told us staff had always supported them correctly, including when using the bath hoist. We discussed this shortfall with the clinical nurse manager who told us they would review and amend the risk assessment immediately.

We found environmental risk assessments had not been completed to make sure people's homes were safe for staff to work in, for example considering uneven paths, poor lighting or the safety of electrical appliance staff had to use. Therefore any potential risks in the person's home that might affect the person using the service or staff had not been identified. We did not see any obvious environmental risks while visiting people at home but the clinical nurse manager told us they would introduce a risk assessment form to cover environmental risks straight away.

Requires Improvement

Is the service safe?

The registered manager told us an external health and safety company had been used to assess risk factors in relation to the agency and provided on-line training for staff.

Staff we spoke with demonstrated a good understanding of people's needs and how to keep them safe. They described the arrangements in place for them to access people's homes while maintaining a good level of security. One care worker told us, "I gain access by using the key safe and always make sure everything is secure before I leave."

The service had a medication policy which outlined the safe handling of medicines. Where people needed assistance to take their medication we saw their care plan outlined the medicines the person was taking and staffs role in supporting them to take them safely. However, in one file we saw there was no clear record of what medication had been taken each time. The person was taking two 'as and when required' medicines [also known as PRN medicines]. Their care worker said they assisted them to take these on a regular basis, which was recorded in the daily records. When we checked the daily records medicines given had not been recorded consistently. For example, one entry said, "Paracetamol x 2 and 2 x other tablets given." The second tablets were listed by name in the person's file, but there was no other record to provide the detail of what the medication was prescribed for, what time it had to be given and who had given it.

The person using the service told us staff always asked them if they wanted their tablets and they decided if they did. No other concerns were raised regarding the administration of medicines.

The clinical nurse manager told us another care company also visited this person and so they were responsible for the rest of their medication. They said they would introduce a more detailed record as soon as possible and in the meantime they would ask staff to record the PRN medications in more detail in the daily records.

The registered manager told us that care staff had undertaken medication training within the first 12 weeks of their employment. Staff comments and the training records we sampled evidenced that this had occurred.

Good

Is the service effective?

Our findings

People we spoke with said staff were competent in providing care and support. They told us they were encouraged to stay as independent as possible, but support was given as and when needed. One person told us their main care worker was "Very good," adding "She knows exactly what she's doing."

Records and staff comments demonstrated staff had received training to meet the needs of the people they supported. Staff we spoke with told us they had undertaken a structured induction when they joined the agency. They said this had included completing the company's mandatory training in topics such as moving people safely, dementia awareness, risk assessment and food hygiene. The registered manager and clinical nurse manager told us new staff also completed the common induction standards and shadowed an experienced staff member until they were confident and competent in their role. A care worker told us, "I had lots of training and material to read when I first started and they [the clinical nurse manager] worked with me until we were both comfortable that I knew how to do things." They also said they were being supported by the company to complete a nationally recognised care award.

The registered manager told us training sessions normally took place twice a week. Records showed that staff had access to various specialists training to help them meet the needs of people who may be supported by the company. Staff we spoke with confirmed topics covered included mental health and personality disorders. The registered manager also showed us a new employee's handbook which they said was being issued to each member of staff.

The registered manager told us staff supervision was arranged as and when needed. They said routinely this would be every 6 months, but if someone needed additional support this would be arranged on an individual basis. However, we saw no documented evidence that formal staff supervision sessions had taken place. The registered manager said this was because staff currently working for the agency had not been in post for six months. We discussed the lack of regular formal supervision for staff with the registered manager in light of the complex care and support staff might be providing; they told us they would be reviewing policies shortly.

The staff we spoke with told us they felt they received appropriate support from the management team. One care worker told us, "Support is there when you need it." We saw a system was in place for annual appraisals to take place, but none of the staff had worked for the agency long enough to receive one. The registered manager told us staffs training needs were assessed when they joined the agency; this was confirmed by the staff we spoke with.

The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. The Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensure that, where someone may be deprived of their liberty, the least restrictive option is taken. The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS), and to report on what we find. We checked whether people had given consent to their care, and where people did not have the capacity to consent, whether the requirements of the Act had been followed. We saw policies and procedures on these subjects were in place.

Care records demonstrated that people's capacity to make decisions had been considered and recorded within the assessment and care planning process. Staff confirmed they had attended training in this subject and demonstrated a satisfactory understanding of their responsibilities regarding decisions being made in people's best interest.

When people required support with food preparation we found staff had received training in the safe handling of food. People using the service told us they were very happy with how this took place and told us care workers also left drinks and snacks for them to eat between visits. One person told us, "She (her care worker) prepares lunch nicely so it looks nice and you want to eat it." Systems were in place to monitor anyone who was at risk of poor nutrition or hydration, but at the time of our visit no one was at risk so monitoring tools were not in use.

People using the service said they would feel comfortable discussing healthcare issues with staff as they arose. Staff described how they would appropriately support someone if they felt they needed medical attention. For example one care worker told us they would call the doctor or their relative, with the person's permission, and stay with them until someone arrived.

Good

Is the service effective?

A care professional we contacted told us, “My experience using Baryen Health Care was good. They supported one of my service users who was in high level of need with a complex presentation and high levels of risk to themselves and others. They [management staff] were professional and were excellent at communicating throughout.”

Good

Is the service caring?

Our findings

During our inspection we visited people accompanied by the clinical nurse manager who introduced us to the person being visited and any staff on the premises. We observed positive interaction between staff and the people who used the service. They were respectful and spoke to people in a caring way, respecting their decisions. One person using the service praised their care worker and told us the quality of care was very good. They added, "I am very happy with everything."

People said they could express their views and were involved in making decisions about their care and treatment. They told us they had been involved in developing their care plan and said staff worked to the plan we saw. Care files contained information about people's needs and preferences, so staff had guidance about what was important to them and how to support them. The staff we spoke with demonstrated a very good knowledge of the person they supported, their care needs and their wishes. One care worker told us, "X [the clinical nurse manager] went through everything with me and there is information in the care plan if you need to check anything."

Staff responses to our questions showed they understood the importance of respecting people's dignity, privacy and independence. They gave appropriate examples of how they would preserve people's dignity. One care worker told us, "I make sure I cover X [the person using the service] up and things are done how she wants them to be done."

The registered manager told us their aim was for every person using the service to be supported by a small team of care staff who knew them well. This meant staff and people who used the service could build up relationships. One person using the service confirmed this adding, "It's the little things that count, having the same person means they know me and how I like things doing."

The registered manager told us they worked with a local forum to enable people to access an independent advocacy agency should they need additional support. Advocates can represent the views and wishes of people who are unable to express their wishes.

Good

Is the service responsive?

Our findings

People we spoke with told us they were happy with the care provided and complimented the staff for the way they supported people. They confirmed they had been involved in planning the care they received, and said the clinical nurse manager visited them periodically to check everything was how they wanted it. During our visit we observed interactions between staff and someone using the service which was focused on their individual needs and preferences. The person being supported said, "I wouldn't change a thing."

Staff told us each person being supported was issued with a care file which was kept in their home, with a copy at the agency's office. Care records we sampled identified people's main needs and any risks associated with their care. We found care plans were factual, but not person centred. For example one person's care plan said they needed full assistance with personal hygiene and dressing, but gave no further details about their abilities or how they liked this carried out. When we visited the person they confirmed they needed a lot of help, but said they could manage to wash their hands and face themselves. We discussed this with their care worker who demonstrated a very good knowledge of exactly what the person could, and could not do, and their preferences, but this was not reflected in the care plan.

We discussed the lack of detail in care plans with the clinical nurse manager who said they would review care plans and ensure additional detail was added so if new staff visited people they would have details of their individual needs and preferences.

We saw care workers completed daily notes about the care and support they had provided. On the whole these provided detailed information about the care given at each visit and any changes in the person's general wellbeing.

When we asked the registered manager how they worked with external agencies to make sure people's needs were met, they told us they met with professionals as and when needed, such as at multidisciplinary meetings. They added that when they were supporting someone with complex needs they also produced weekly reports to other agencies involved, to identify any problems and look at strategies to rectify them.

The company had a complaints procedure which was included in the information given to people at the start of their care package. We saw a system was in place to record any complaints or concerns received. This included the details of the concern, actions taken and the outcome. The registered manager told us no complaints, apart from two anonymous concerns we had referred to them, had been received. They had investigated these issues and reported their findings back to us.

People we spoke with told us they would feel comfortable raising concerns with their care worker or the management team. One person said, "I have no complaints, but if I did I would phone X [the clinical nurse manager] and they would sort things out."

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the service had a manager in post who was registered with the Care Quality Commission. They took day to day responsibility for the running of the agency alongside the clinical nurse manager. The registered manager told us they were part of a forum that was discussing topics around the new regulations and the fundamental standards being introduced in April 2015. They said they hoped this would help prepare them for future changes.

People we spoke with said they were happy with the service they received and could not think of anything they would like to change.

The provider had a system in place to gain the opinions of people who used the service, but due to the low number of people supported, often for a short period of time, this had not been used. They told us once the service was more up and running they would formally gain people's views. In the meantime people's satisfaction had been gained through care reviews and informal discussions during visits to see them at home. One person told us, "X [the clinical nurse manager] comes out all the time to check things are okay." During a visit to someone using the service we saw they knew who the clinical nurse manager was and their friendly approach to each other showed they spoke with each other on a regular basis.

We found the same applied to staff consultation. The staff we spoke with had either not worked at the service for very long, or had other jobs and worked for the agency for short periods of time. They told us they could voice their opinion openly to the registered manager or the clinical nurse manager if they needed to discuss anything. However, we found there was no structured system in place to provide staff with regular formal support session to give them the opportunity to discuss any concerns or training needs they might have. When we asked if there was anything they felt the service could improve, they did not identify any areas for improvement. They said they enjoyed working for the agency and were happy with how it operated.

Policies and procedures were available to inform and guide staff and people using the service. The registered manager told us these were to be reviewed annually or when anything changed. They said the policies had been completed following a full assessment of the agency by an external company.

We saw an audit system was available to enable the management team to check company polices had been followed and the service was operating to expected standards. However, as the service provision to date had been limited, it had not been fully utilised at the time of our visit. We discussed the shortfalls found in recruitment and care records with the management team, which indicated that the use of quality audits with regards to these areas would have been beneficial. The registered manager told us all recruitment and care records would be audited and any shortfalls addressed.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **Appropriate background checks were not consistently undertaken before staff began working for the agency.**