BWA Health & Care Services Ltd

Blay Domiciliary Services

Inspection report

International House
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Date of inspection visit:
26 April 2016

Date of publication:
01 July 2016

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on the 26 April 2016 and was announced. The provider was given 24 hours' notice because the location provides domiciliary care and we needed to be sure that someone would be at the office.

Blay Domiciliary Services is a domiciliary care service providing care and support to people living in their own homes. The office is based in the city of Derby and the service currently provides care and support to people living in Derby and surrounding areas. At the time of our inspection there were 116 people using the service.

Blay Domiciliary Services had a registered manager in post. 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.

People told us they felt safe with the staff and the support they received. Staff knew how to recognise signs of abuse and who to raise concerns with. People had assessments which identified actions staff needed to take to protect people from risks associated with their specific conditions, although some of these needed to be improved with additional information. People were supported to take their medicines as prescribed.

People confirmed that staff usually stayed for the time allocated for the call but some people told us that staff were often late for the call. People were not always notified that carers were running late. People knew how to make a complaint and most people found the service to be approachable and responsive to their concerns. A small number of people felt that the service did not listen or act upon their concerns.

The provider regularly sought the views of people who used the service and their relatives. People told us they were happy with how the service was managed overall. Some people felt that office staff were not approachable and could be abrupt at times.

People were supported by the number of staff identified as necessary in their care plans to keep them safe. There were robust recruitment and induction processes in place to ensure new members of staff were suitable to support the people who used the service.

Staff had the skills and knowledge to ensure people were supported in line with their care needs and best practice. There was effective communication between office staff and care staff and regular supervisions which supported staff to meet people's needs.

People made decisions about their care and support needs. Staff sought consent before they supported people and showed respect for people's choices and decisions. People's plans of care reflected the support they required and promoted people's independence.

Where necessary, people were supported to eat and drink and access other health care professionals in order to maintain their health.

People told us they were happy with the support they received and had developed positive relationships with staff. People found the staff to be kind and caring. Staff understood their role in supporting people to maintain their privacy and dignity. Staff were knowledgeable about the needs of people and took into account their preferences. The provider had plans to develop the format of people's care plans to ensure care was provided in a person-centred way.

The provider had established processes for monitoring and developing the quality of the care people received. These included observations of working practices and audits on care records.

We received positive feedback overall about the care and management of the service from social workers who had been involved in commissioning services for some people who used the service. They confirmed that they received occasional complaints from people using the service around late calls but had not received any complaints about the quality of the care the service provided.

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.

Risks to people had been assessed, although some risk assessments lacked detail to support staff to keep people safe.

Recruitment procedures were thorough to ensure the staff employed were suitable to work with people. There were sufficient numbers of staff available to meet people's needs. People using the service experienced frequent late calls.

People told us they felt safe using the service. Staff knew what to do if they had concerns about the safety and well being of people who they supported.

Is the service effective?

Good

The service was effective.

Staff had the training they needed to provide effective care and support.

Staff were aware of the principles of the Mental Capacity Act 2005.

People were supported to maintain good health.

Is the service caring?

Good

The service was caring.

People and their relatives gave consistent positive feedback that they were supported by staff that they liked and who were caring towards them.

Staff understood the importance of respecting people's right to privacy and dignity when they supported people who used the service.

Is the service responsive?

Requires Improvement

The service was responsive.

Most people felt that the service was responsive and they received their calls on time. Some people felt that their calls were frequently late.

People's needs were assessed and care was planned and delivered to meet their needs.

There was an appropriate complaints procedure in place. People knew how to make a complaint but not all people were confident that their concerns would be listened to and acted upon.

Is the service well-led?

Good

The service was well-led.

The provider undertook audits to check the quality and safety of the service, which included seeking the views of those who used the service.

People generally felt that the service was well-led, although some people felt that communication could be improved between themselves and office staff.

Blay Domiciliary Services

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 26 April 2016 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure someone would be in the office to meet us.

The inspection was carried out by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert-by-experience for this inspection had expertise in services for older people.

Before the inspection, we asked the provider to 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 returned the completed PIR.

We reviewed the information we held about the service, which included information of any concerns received and 'notifications'. Notifications are changes, events or incidents that the provider must tell us about. We also had contact with commissioners for health and social care, responsible for funding some of the people who use the service, to gain their views about the service.

We spoke with 14 people using the service and two relatives whose family members' used the service. We also spoke with the registered manager, the senior manager, a care co-ordinator and four care staff.

We looked at the records of eight people, which included their care plans, risk assessments and daily care records. We also looked at the recruitment files of six members of staff, a range of polices and procedures, minutes of staff meetings and information relating to quality assurance and good governance.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe with the staff that supported them in their own homes. One person told us, "I am very safe." Another person told us, "I am treated very well by the care staff who come to my house."

The senior manager carried out initial assessments of people's needs and also assessed risks to their well being and safety. These included environmental risks, the use of equipment and risks related to their health or other needs. Risk assessments had been clearly recorded and there were guidelines in place to reduce the likelihood of harm. We saw that some risk assessments lacked detail to support staff to keep people safe. For example, one person had been assessed as being at high risk of falls. We saw that the risk assessment included equipment to be used to support the person in the bathroom but did not include the person's walking frame or how staff should support the person to move around their environment safely. Another person had been assessed as at risk during assisted transfers due to being 'sleepy'. The risk assessment did not provide staff with sufficient guidance on the nature of the risks or how to reduce the risks to the person during assisted transfers. We discussed this with the registered manager who told us that they would ensure risk assessments were reviewed and recorded to ensure that they were fit for purpose.

Staff we spoke with were consistent in their responses about what actions they would take in the event of a general emergency. Staff were able to describe the actions they had taken in response to specific health and medical emergencies people they supported had experienced. This showed that staff had the right mix of skills and experiences to meet people's needs safely.

We looked at the staff rotas for the service over a two-week period, The registered provider used a computer based system which showed which staff supported each person. Staff were required to text the service after each call to let the administration team know that they had completed the call. One person who used the service told us, "I have the same carers. They never let me down, they always come even if it's late." Another person told us, "I don't have the same carers each day and they come at different times." A number of people who used the service were unhappy that they received late calls and were not always notified that care staff were running late. Staff who we spoke with felt that they were generally on time for calls but could be late if some calls took longer than expected. We discussed this with the registered manager who explained that calls had a 30 minute window either side of the agreed call time. They felt that people using the service did not always understand this although they had discussed this with people during the initial assessment. They acknowledged that care staff could be late and had taken measures to improve staff timekeeping. We saw minutes of a recent staff meeting reminding staff to contact the office if they were running late so that the office could inform the next call. The registered manager agreed to discuss timekeeping with people who used the service as part of measures to improve call times.

All the staff we spoke with told us that they felt people who used the service were safe and understood their role in keeping people safe. One staff member told us, "I have no concerns about people's safety. If I had any concerns about someone I would talk to my team leader and document information in the report folder at the office for someone to pick up straight away." The staff member explained that the report folder enabled

staff to document a summary of their concerns and would be followed up by a telephone call from the senior manager. Another staff member told us, "People are kept safe. I know how to keep them safe through information in their care plans."

The provider had policies and procedures regarding safeguarding adults and whistle blowing which were given to staff as part of their induction. Staff we spoke with told us that they had received training in safeguarding and this was confirmed in staff training records. Staff were able to demonstrate their understanding of safeguarding and their responsibilities. One staff member told us, "I have never had to deal with abuse but if I suspected someone was being abused I would report this to my line manager and the registered manager. If I felt that they were not doing anything about it or were implicated in the abuse, I would contact the local safeguarding team or speak to CQC." Another staff member told us, "If I suspected abuse, for example someone was being neglected, I would report this to my manager straight away. I know abuse is also reported to social services and CQC."

We looked at how the service supported people with their medicines. People who received support to manage their medicines had a medicine assessment tool in their care plans. This tool detailed the level of support the person required and recorded the person's consent to the support. People who used the service told us, "I receive my medicines on time and it is recorded in my file that I have to have it." Another person told us, "The care staff give me my tablets." Medication Administration Record sheets (MARs) were available within people's care files. We saw that the senior manager carried out regular audits on people's MARs charts and identified errors. For example, audits had identified some MARs charts had missing signatures by staff which were required to confirm they had supported someone to take their medicines. The registered manager told us that there had been several medicine errors within recent months and they had addressed this through re-training staff and more frequent audits. We saw that the last month of audits identified that all MARs charts had been completed correctly. Staff files confirmed medicine awareness training and that competency observations had been completed. We saw that the provider had a medicine policy and procedure available for staff to refer to.

People's safety was supported by the provider's recruitment practices. We looked at staff records and found all relevant checks had been completed before staff worked unsupervised. Checks included identify checks, previous employment checks and checks with the Disclosure and Barring Service (DBS). The DBS check helps employers to make safer recruitment decisions and prevents unsuitable people from working with people using the service. These records had been well maintained.

Good

Is the service effective?

Our findings

The people who used the service and their relatives were happy with the care staff who supported them. Some of the comments included, "The carers who come are the best", "They [care staff] do all they can to make life good", "My carers are really well trained" and "I have the best of the best". Some people had concerns that they did not always have regular carers. However most people told us they did have regular carers for their calls. The registered manager told us that people usually had the same carers but temporary carers were assigned in the event of regular carers taking absence or holidays.

People had confidence the staff had the skills and knowledge to meet their needs. All the staff we spoke with told us they received a variety of training to enable them to carry out their job effectively. One member of staff told us, "The training I have is really good, I never have to ask for training, it is always planned. I can ask for further training to develop my skills and this is encouraged by the managers." Another member of staff told us, "I was new to care and the training has given me the skills and confidence I need to provide care." Staff told us they had received training through classroom learning, e-learning and specialist training from nurses and healthcare professionals in order to support people's individual health needs. Some staff expressed a preference for face-to-face training as opposed to e-learning as they felt they retained knowledge more effectively when training was delivered in person. We looked at staff training files and saw that a range of training was undertaken by the staff team. This meant that staff had the skills and knowledge they needed to support people effectively.

We looked at the provider's induction process and staff we spoke with confirmed that they had undertaken induction prior to working for the service. One staff member told us, "My induction was really good, I was new to care and had chance to undertake theory training in the first week and then went out and shadowed experienced staff in the second week. By the end of the second week I was able to go out on my own but only if I felt comfortable to do so. I knew I had the choice of asking for more induction or shadow shifts if I felt that I needed them." Another member of staff told us, "I completed my induction which included learning about the job and shadowing other staff, This gave me the chance to get to know people before I started to provide care for them." We saw documentation on staff files that confirmed staff had completed induction which included key areas of the role and shadow shifts. This meant that staff had received induction and training to enable them to be effective in their roles.

We looked at the supervision and appraisal process for staff. Staff told us and records confirmed that staff met regularly with their line manager for supervisions. We saw that supervision was used to evaluate staff working practices and identify areas of improvement or development in addition to discussing key issues within the service. One staff member told us "My supervision gives me the opportunity to share information with my manager and discuss ideas." Another staff member told us "My supervision sessions are good, I can raise problems with the office manager. However, responses to problems from managers can be slow sometimes, although they do eventually get back to you." Overall staff we spoke with felt well supported. One staff member told us "The office really supports us to do our job. They are quick to communicate changes and information to us by text and ask us to respond so they know we have all received the message." We saw that appraisal records were up to date.

The law requires the Care Quality Commission (CQC) to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way. MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when it is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

Care records showed that the principles of the MCA Code of Practice has been used when assessing people's ability to make decisions. Staff were able to describe how they obtained consent to care and treatment from the people they supported. One staff member told us, "I always ask people if they are okay with what I am doing and watch their facial expressions to check they are happy." Another staff member told us, " I ask the person and their family members if they are happy with their care and I make sure I record this in the care records." One person who used the service told us, "The carers always ask before they do anything for me." We saw that people had signed the terms and conditions of their care and consented to care being provided.

People who we spoke with were happy overall with the support they received from staff to help them with the preparation of meals and drinks. We saw that, where appropriate, staff completed food and fluid intake charts for people that may be at risk of poor nutrition and hydration. One person had expressed concerns that late calls had an impact on their meals which were time critical. We saw that they had discussed this with the manager and the manager had made improvements in the staff timekeeping which meant they were receiving support to have their meals in a more timely manner. Care records reflected people's preferences in choice of meals, for example one person was unable to eat certain meats whilst another person liked small meal portions. We looked in people's daily record notes and saw that staff had respected people's choices and preferences.

We discussed with people who used the service how their healthcare needs were met. They explained that if they needed assistance staff would help them. Some people were able to undertake this independently. People's health needs had been assessed and recorded as part of their care plan. Daily care notes made by care staff indicated that people's health needs were being monitored. Within people's care plans there were details of the person's GP and next of kin. Staff said they would contact them if they were asked to do so. One member of staff was able to provide an example where they had summoned emergency assistance for a person who they had found on the floor and contacted their next of kin to advise them of the incident.

Good

Is the service caring?

Our findings

All the people using the service and relatives we spoke with said the staff were caring. Some people described what this meant for them in practice. For example, one person told us, "My carers are the only people I see each day. I look forward to them coming as otherwise I would have nobody to talk to. They do everything I want, it's never a trouble." Another person commented, "The way I am treated is excellent by all carers." A relative told us, "I am very happy with how my family member is treated and her care is excellent."

People using the service felt that staff treated them with dignity and respect. One person told us, "I am always treated with respect at all times." Staff told us about the people they supported. One staff member explained, "It's important to get to know the person and how they like to be supported. When I am assisting with personal care, I make sure the person is covered where possible and the door is shut to protect their privacy and dignity." Another member of staff was able to describe how they supported people with their personal care if they needed extra assistance, even if it meant they provided care beyond the agreed call time. They understood their responsibilities to protect and uphold people's dignity and welfare.

The senior manager was able to explain different people's needs and explained she always undertook the initial assessment so that she had a clear understanding of people's needs. Staff who we spoke with described how they showed care in their role and towards people they supported, for example, giving people time to do things for themselves where they were able to. Staff had a good understanding of people's needs and individual preferences and they could describe people's personal care preferences and followed preferred routines detailed in people's care plans.

Most of the people using the service were involved in the planning of their care. One person told us, "I have a care plan, yes. I was there and involved when it was written." A small number of people felt that they had not been involved in the planning of their care following hospital discharge but were aware that they had a care plan and confirmed that they had a copy of the care plan in their home and they were in agreement with it. Records confirmed that people's written consent to care was sought and obtained where possible. There were written agreements in care plans signed by the senior manager and, wherever possible, the person using the service and/or their representatives.

People were provided with a range of information about the service. This included the statement of purpose and service user guide which provided contact details for the service, the aims and objectives for the service, consent and people's charter of rights and how to make a complaint.

Requires Improvement

Is the service responsive?

Our findings

Most of the people using the service and relatives we spoke with said care staff provided a personalised service that was responsive to people's needs. One person told us, "The care staff always ask and listen to what I want." Another person told us "My carers provide my care in the way that I want it."

Some people using the service had concerns regarding the timing of their calls. Whilst most people felt that they had regular carers who arrived on time, some people were unhappy that they had frequent changes in carers who were often late. They told us that they were not always informed when carers were running late which lead to them feeling frustrated and anxious. We looked at call schedules and care records and saw that there was variation in timings of calls by 10-60 minutes of the agreed call time. Staff who we spoke with felt that they were usually on time for their calls with the exception of short calls where they could often stay over which made them late for their next call. Some staff told us they started morning calls earlier to ensure that they were not late for later calls. We discussed timing of calls with the registered manager who told us that there was an agreed variation of up to 30 minutes either side of the agreed call. They told us that this had been discussed with each person prior to them receiving care from the service but they had not recorded this within people's care plans or care agreements. They told us they would speak to people who used the service and explain this variation to them to ensure people understood and were in agreement with the variation.

Records showed that the service was responsive to people's needs. For example, one care plan highlighted that the person could experience good and bad days. The care plan summary clearly explained the response required from staff to support the person when they were experiencing bad days including support to ensure the person did not neglect their personal care. A second care plan detailed the person's specific needs in relation to their sensory impairment and the specific support the person needed to enable them to maintain their independence.

Some care plans lacked detail. For example, one read 'requires assistance with personal care' but didn't explain what this entailed or how the person preferred the assistance to be given. Another read 'staff to support with meal preparation' but again there was no explanation as to how staff should do this. In some cases information from the local authority's support plan and not been transferred into care plans in sufficient detail to enable staff to provide responsive care if this was the only information they had.

Care plans were focussed on the healthcare needs and tasks to be undertaken for the person using the service. We found that very few care plans included information about people's life history, key life events or things that were important to the person. We asked staff how they learnt what was important to people and how people preferred to be supported. Staff told us that they initially learnt about people's health needs and tasks to be undertaken by reading people's care plans and talking to the senior manager who had undertaken the assessment. Staff said that once they started calls, they talked to people to find out more about them. Some staff were concerned that they didn't always have the opportunity to meet people before they started to support them. They told us that they found this difficult as they didn't really know the person and could only go on the guidelines in the care plan.

We discussed this with the registered manager who said that information was always given verbally to the care staff and through the person's care plan prior to them commencing any care. She acknowledged that care plans could be developed to include information about people's life history and key events to help ensure that staff provided personalised care rather than simply completing tasks. She told us that this was something she had already been discussing with the senior manager to develop care plans into a more person-centred approach.

People's care plans were reviewed on an annual basis or more often where needs changed. Each of the records we saw had an up to date review in place. The review included if the person was happy with the service, if they felt their needs were being met and any changes required. We saw that comments in reviews were usually positive but where people had requested changes, for example an earlier call, it was not clear to see how the service had responded to the request.

Most people were confident to make a complaint in the event that they had concerns. Comments we received included, "I would contact the office if I had a concern and I am certain it would be sorted out straight away", "I contact the office directly and talk to them, Nothing is too much trouble." A small number of people felt that there was little point in complaining as nothing was ever done. Their concerns were mainly around the timing of calls.

The provider had a complaints policy in place. This was available to people through the service user guide. We saw details of one complaint on file that had been received in the last 12 months. We saw that the provider had acknowledged the complaint and referred the complaint to a third party which was an external health professional. Complaints were also held on the provider's computer based system. We recommended that the provider keep a central record of complaints to enable them to identify trends and monitor outcomes of complaints.

Good

Is the service well-led?

Our findings

People using the service told us they were happy overall with the quality of care and support provided. People were very positive about the quality of the care they received. They told us that they felt they had positive relationships with their carers and felt respected and valued by all the carers. We received mixed responses on how people rated the quality of the management of the service. Some people told us that they thought there was a lack of communication between the office and people who used the service. People told us that they felt the attitude of some office staff came across as abrupt and rude whilst others had no hesitation in contacting the office on a regular basis and reported positive communication on every occasion. We raised this with the registered manager who told us they would discuss this feedback in the next office meeting and work with managers and people using the service to establish positive relationships.

Staff were generally positive about the leadership of the service. They told us "Communication between office staff, managers and care staff is really good. We are told straight away if there are any changes that we need to be aware of. We can raise concerns directly with our team leader or leave a note in the concerns folder in the office for the senior manager." Another staff member told us "I think the service is well-led. The [registered] manager makes sure that everything is done the right way." One staff member felt that managers did not always listen to or act upon staff concerns.

Staff meetings were held regularly and we saw that they were well attended by all levels of staff. Meetings were used as an opportunity to reflect on working practices, share information and identify areas where the service needed to improve. We saw that staff could raise concerns for discussion during the meetings. We also saw that a separate meeting was held for office staff which involved all key administration and senior management roles. These meetings enabled the management team to review the service aims and objectives and agree action plans to make improvements to the service.

The registered manager was not involved in the day to day running of the service but was in regular contact with the senior manager. The senior manager was in day to day control of the service and had a personal knowledge about the people using the service and each member of staff. They were supported by a team of office staff who helped with co-ordinating staff rotas, staff recruitment and monitoring the quality of the service provided. The registered manager understood their responsibilities and what was expected of them regarding their legal obligations. They told us they worked closely with local authorities where they provided care and kept themselves up to date with good practice.

The provider had systems for monitoring the quality of the service. Monitoring included spot checks on staff to make sure they were meeting people's needs and telephone calls to people using the service to ensure they were happy with their care. The senior manager undertook regular audits on care records. Audits included daily logs, care plans and medicine records. We saw that where issues had been identified, for example, a missing signature on a MARs, the senior manager had identified this and taken appropriate action to address the error. There was an out of hours call system and managers were available at all times to speak with people using the service or staff who needed them. This was confirmed by people using the

service and staff.

The people using the service were consulted and their opinions sought on things they were happy with that they thought staff did well. They were also asked to comment on things they felt were not working well and where the service needed to make improvements. This feedback was obtained through regular satisfaction surveys throughout the year but also through informal feedback from people and their relatives. The results of satisfaction surveys were collated to produce a service performance report. We looked at survey results for 2015. We saw that generally people were happy with their care but some dis-satisfaction had been recorded where people felt the level of information about complaints was poor or were unhappy about their calls. We noted that the provider had identified action in response to people's concerns and saw that action had been followed up in staff meetings. The provider had not shared the collated information from satisfaction surveys or the action plan with people using the service. They told us they were in the process of reviewing their quality assurance processes and would look at how they could include feedback to people using the service as part of the review.

We saw that the provider monitored accidents and incidents which were clearly recorded and included follow up action where appropriate. The provider's systems enabled managers to identify any trends or respond to any changes or patterns to ensure people were kept safe and received quality care.