Carebridge Staffing Limited

Carebridge Staffing Ltd

Inspection report

2 London Bridge
London
SE1 9RA

Tel: 02038791520

Date of inspection visit:
17 August 2018
21 August 2018

Date of publication:
18 February 2019

Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

This comprehensive inspection took place on 17 and 21 August 2018 and was announced. We gave the provider 24 hours' notice of our intention to visit because this is a small service and we wanted to be sure the registered manager would be available to partake in the inspection process. This is the first inspection we have carried out since the service registered with the Care Quality Commission (CQC) in August 2017.

Carebridge Staffing Ltd is a domiciliary care agency providing care and support to adults and children living in their own homes in London, Essex and Hertfordshire. Whilst we have taken into account any wider social care and support provided to people in their homes and in the community, the CQC carried out this inspection only in relation to the regulated activities of 'personal care' and 'treatment of disorder, disease or injury'. 22 people were using the service on the first day of our inspection. On the final day, 20 people were receiving a service. Nearly all of these people required support with personal care tasks.

The service 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.

The provider had systems in place to assess people's care needs and to plan their care in a way which met their needs.

People were not always being protected from avoidable harm because potential risks to people and/or others were not being identified through a robust risk management process.

The provider made sure that people's capacity was assessed and that care was delivered in people's best interests.

The provider had appropriate medicine's policies and procedures in place. This included assessing the support people required to take their medicines safely and as prescribed. Staff completed appropriate medicines training and competency assessments before supporting people with their medicines. Staff completed medicines administration records (MARs) and these were returned to the office for auditing purposes.

The provider operated safe recruitment measures. The provider obtained sufficient proof of identification, requested and verified employment references and carried out Disclosure and Barring (DBS) checks before staff started work.

The provider carried out appropriate training and spot checks to ensure that care workers were suitable for their roles and had the right skills to care for people. At the time of our inspection there were enough nursing and care staff deployed to support people with their needs.

There were measures in place to ensure that staff understood how to promote people's dignity and this was regularly checked by managers. People told us that they were treated with respect by staff.

The provider gathered information and took account of people's cultural needs and preferences to ensure staff supported people in an appropriate manner.

People received support to eat and drink where this formed part of an agreed package of care.

Most people had regular reviews of their care and the management team sought people's feedback to make sure they were happy with the standard of care provided.

When incidents had taken place or complaints had been received, managers acted on these and investigated what had taken place. Staff told us that incidents, accidents, concerns and complaints were discussed at team meetings and in supervision sessions with a view to promoting understanding and learning.

Staff were positive about the support and guidance they received from the registered manager and her team.

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

Not all aspects of the service were safe.

Generic risk assessments did not always include risks associated with the use of oxygen cylinders within the home. An example risk assessment sent to us by the provider had not been reviewed for over a year.

Staff completed competency based training in the safe administration, storage and disposal of medicines.

Sufficient numbers of skilled and experienced staff were employed to meet people's needs.

People were protected from the risk of bullying and abuse.

Is the service effective?

Good

The service was effective.

People were supported to maintain healthy nutrition and hydration.

People were cared for by staff who received support and training to help them meet their needs.

Where people lacked capacity to make a decision about their care, their rights and best interests were protected.

Is the service caring?

Good

The service was caring.

People and their relatives had positive relationships with staff.

People were treated with dignity and respect and their privacy was protected.

Where possible people were involved in the planning and review of their care.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support that was responsive to their needs.

People's complaints were investigated and responded to.

People were supported at the end of their lives.

People and their relatives felt able to raise a concern or complaint and were confident it would be acted on.

Is the service well-led?

Good

The service was well led.

There was a clear management structure in place.

People who used the service, their relatives and staff were encouraged to give feedback about the service and their feedback was acted on.

There were quality monitoring systems in place which were used to drive improvement at the service.

Carebridge Staffing Ltd

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 was a comprehensive inspection. Prior to our inspection we received a complaint from two family members regarding the delivery of unsafe care by staff employed at the service. We were also contacted by healthcare professionals from Thurrock Clinical Commissioning Group (CCG) who raised some concerns in relation to care provision and service management. We discussed these issues with the registered manager during the inspection and followed up these concerns with the CCG following our inspection. This inspection was carried out partly in response to concerns received and because we are required to inspect all care services within the first year of their registration with the Care Quality Commission.

Prior to carrying out this inspection we looked at information we held about the service, such as statutory notifications, enquiries and complaints. Statutory notifications include information about important events which the provider is required to send us by law. We also asked the provider to complete a provider information return (PIR). This is a form which asks the provider to tell us what they think they are doing well and their plans to develop the service. We used this information to plan our inspection.

This inspection took place on 17 and 21 August 2018 and was announced. We gave the provider 24 hours' notice of our intention to visit because this is small service and we wanted to be sure the registered manager would be available. One adult social care inspector completed the on site inspection. Following the inspection an expert by experience contacted two people using the service and 11 relatives to gain their views about the service and the way in which it is managed. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During our site visit we looked at records of care and support for six people who used the service and records of medicines management for five people. We reviewed recruitment and supervision records for six members of staff and looked at records relating to the management of the service, such as quality assurance audits, health and safety documents, policies and procedures, training records and staff communications.

We spoke with two care staff, two registered nurses, an administration staff member, the registered manager and a deputy manager.

Requires Improvement

Is the service safe?

Our findings

The provider had systems in place to safeguard people from abuse and to protect them from avoidable harm. The provider had adult and child safeguarding policies and procedures in place which had been updated in June 2018. Both sets of policies were comprehensive and provided staff with clear guidelines in relation to identifying, reporting and preventing abuse. Staff told us they were up to date with their safeguarding training and clear about the action they would take in order to keep people safe including; using the provider's whistleblowing policy and reporting any concerns to the management team and external authorities.

Records confirmed that safeguarding concerns had been reported to the relevant safeguarding authorities, the Care Quality Commission (CQC) and the police where appropriate. We were aware that two safeguarding concerns in relation to allegations of unsafe medicines administration and criminal activity are currently being investigated by the registered manager and the relevant Clinical Commissioning Group. The police are involved in investigations relating to the alleged crime incident. We have asked the registered manager to notify us of the outcome of investigations when they are known. If required, we may take further action to ensure care and treatment is delivered to people in line with the provider's registration requirements.

We asked people using the service and their relatives if they felt safe and whether they trusted the staff who visited them in their homes. Responses included, "I have no anxieties about [my family member's] safety", "I know [my family member] is safe with the carers who come", "My [family member] is in safe hands" and "We feel safe with the carers."

Staff completed generic risk assessments for each person using the service. These covered areas such as safety within the home, mobility and the use of mobility aids, personal care provision and skin integrity. Staff told us, and records confirmed that generic risk assessments were reviewed on a regular basis and updated when people's needs changed. At the time of our inspection, we did not see risk assessments or specific guidelines in place where people had percutaneous endoscopic gastrostomy (PEG) tubes in situ (PEG is an endoscopic medical procedure in which a tube is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate) or where airway suction devices were in use and/or where people required an additional oxygen supply via a cylinder. The registered manager has since sent us an example of airway clearance management guidelines provided by a hospital trust. This information was dated 22 September 2017. An accompanying care plan showed a review date of 13 January 2017. Therefore, we can not be assured that specific risk assessments and guidelines are being reviewed in a timely manner.

We asked people if they received their medicines in the way they preferred and at the right time. Comments included, "The carers do the medicines and this works well, they are safe and on time, the charts go away for audit by our link nurse", "The carers give the medicines and as far as I know it is all on time and accurate. They are always sending papers off to the guy who runs the carers so I presume the medicines chart would go too" and "The carers give the medicines and I believe they are accurate and on time." However, we heard from one relative that administration and recording of medicines was not always correct and that errors had

occurred. We spoke to the registered manager regarding this matter who acknowledged recording errors and told us that the staff members involved had been asked to write reflective statements, undergo further training and attend increased supervision sessions. We were told and records confirmed that the provider's medicines policy and procedure had also been revised as a result of this error. A revised medicines administration record (MAR) was in place to ensure all recording information was accurate and dated. This demonstrated that the provider endeavoured to learn from mistakes and make any necessary improvements to service delivery where and when needed and in a timely manner.

Staff completed competency based training in the safe administration, storage and disposal of medicines. Appropriate MARs were in place in people's care documentation. The registered manager told us MARs were collected from people's homes on a regular basis and checked by senior staff before being archived safely and securely. We looked at a small sample of MAR charts and noted that apart from one, these were fully completed with no obvious gaps, errors or omissions.

Staff underwent training in correct moving and positioning techniques and this was refreshed as required. Relatives told us, "[My family member] is more or less bedbound and has a medical bed which all the carers seem very efficient with" and "[My family member] has every bit of equipment under the sun and I have total confidence that the carers are safe with [them] and all that [they] need."

Staff were employed following a thorough recruitment procedure. Records showed that references were requested and verified and that criminal records checks had been carried out for staff before they started work at the service. The provider's safeguarding policy made it clear that they would make referrals to the DBS if they had concerns that a staff member has caused harm, or posed a future risk of harm to vulnerable groups, including children. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children.

We asked people if staff members arrived on time and whether they had regular care staff attending. Responses included, "We have regular carers and they are as on time as they can manage, the traffic round here is really bad", "The carer gives us a ring if [they] are going to be really late", "Mostly you could set your watch by them but there have been a few late visits just lately, there are dreadful road works" and "I always have two and mostly it is my regulars." People also told us, "They say we have a wide window of time for care but it is very variable within two hours which is very difficult to cope with" and "We have regulars although they are in the process of introducing new ones. These always shadow first and we always have warning." The registered manager told us that staff visits were not routinely monitored because care packages were delivered by staff teams that were reliable and trustworthy. Some of the care provided was 24 hourly or covered several daytime hours. The registered manager told us that to date, no care visits had ever been missed.

Staff had access to personal protective equipment (PPE) such as gloves and aprons, to help prevent and control the spread of infection. Staff were required to wear uniform tunics or polo shirts and name badges (where appropriate) when visiting people they provided support to.

Good

Is the service effective?

Our findings

People using the service and their relatives confirmed they were involved with the initial and on-going planning of their care and possessed a copy of their care plan. Relatives told us, "We have a care plan and the family were involved with it", "[My family member] has a huge care plan with everyone's contributions there" and "We have a care plan and we were all involved in drawing it up." Staff confirmed they always read through people's care plans before they began delivering care and support to people using the service. A member of staff told us, "We always get a chance to read the care plans. If I ever get stuck, [the office staff] are brilliant with advice."

Where possible, people had signed their care documentation in agreement of services to be provided. Care plans were updated as and when people's needs changed and reviewed in line with the provider's policies and procedures. Relatives commented, "We haven't needed to make changes but they adapt to what [my family member] wants" and "[Staff] are with [my family member] for such a long time each day and night that changes are easily made."

The provider had systems in place to monitor care delivery. Staff completed daily log and communication sheets detailing the care and support tasks they had provided, making note of any issues, concerns and/or recommendations. People confirmed that daily records were completed and told us, "Before they go, they write down what they have done and how my [family member] has been today", "I see them writing things down before they go" and "They write in a book when they have finished." Any identified concerns such as people appearing unwell, declining their medicines, any changes to skin integrity or food and fluid intake and no response to calls were communicated to the office. Concerns were recorded by senior staff who provided further advice and/or took the necessary action required.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. We found the provider was working within the legislation and care records evidenced that consent to care and support had been obtained and recorded. Staff demonstrated a good understanding of how they supported people to make their own decisions in all aspects of their lives when this was possible. One member of staff told us, "It's hard to get consent sometimes from people with [advanced] dementia. We give encouragement, we ask permission, we ask 'do you mind', we're always asking people if all is fine."

People's care records included information about their medical diagnoses and how this may affect them. Staff had recorded when they had reported concerns about people's health and the actions they had taken in response to these. This included contacting emergency services, GP services or making referrals to occupational therapists, speech and language therapists, wheelchair services and district nurses. Records

we reviewed confirmed that referrals were made to health care professionals, for example, peoples GPs and specialist nursing teams, when this was required.

Staff were required to support people to eat and drink enough and maintain a balanced diet where this had been agreed as part of people's care package. People's views were mixed about how this task was achieved. We asked people if they thought staff had the training and skills to meet their needs. Comments included, "[Staff] do most meals and they do them nicely and again try to give a choice", "When I am not here they will cook a meal and give it to [my family member] and this works well", My [family member] is on continual feeding which [staff] manage" and "[My family member] is fed through a gastro [PEG] and they look after that." One relative complained, "This is one of the main problems, as I never know when they are coming, makes fitting food in very difficult. My [family member] doesn't like me feeding [them] but otherwise food will be too hot or stone cold before [they] get it."

New staff members were required to complete an induction which included amongst other topics; fire safety, first aid in the workplace, health, safeguarding, moving and positioning, mental health legislation, food hygiene, hydration, food and nutrition, handling medicines and infection prevention and control. Staff we spoke with told us they had completed an induction prior to working with people using the service and essential training was refreshed on a regular basis. On completion of induction and prior to being sent to people's homes staff received a staff handbook and signed a declaration stating they agreed to abide by the contents and the terms and conditions of employment. We saw evidence to confirm staff had completed a range of training to ensure they had the skills and abilities to meet the assessed needs of the people using the service.

Good

Is the service caring?

Our findings

We asked people using the service whether they felt well cared for by the service and staff. Comments included, "Yes, [staff] are always polite", "Yes, [staff] are always considerate" and "[Staff] are in our house for long periods and they respect our home."

We asked people if staff showed them respect and maintained their dignity when supporting them with personal care tasks. Comments included, " We have an ensuite bathroom and they make sure that even though the bathroom is tiny that everything is closed before we start", "[Staff] listen to what we have got to say which means a lot", "[Staff] make sure [my family member] is never exposed and they don't get cross with [them]" and "I have no doors to my living room and they are very careful not to cause embarrassment especially if my family members are at home." One person told us, "I was really apprehensive about this before it started but they are all very mindful of my dignity."

We were told that staff were kind and compassionate. Relatives told us, "[Staff] totally respect my [family member] and include [them] in all [their] care", "They treat us as if we were friends", "[Staff] always treat my [family member] like a princess, [they] like their company" and "They treat my [family member] very well, sometimes I hear [him/her] laughing when they are here."

Staff understood people's communication needs and were mindful of people's health and well-being. Relatives told us, "They talk to my [family member] all the time and they recognise the signs when [they] are tired or unhappy", "They call [my family member] by [their] name and talk to [them] even when [they] can't reply" and "They always call [my family member] by name and take their time with [them]" and "Even when [my family member] is having a bad day, [staff] talk to [him/her] and distract [them] from [their] distress."

People's care plans contained some information about their life stories, preferences for their care and their religious and cultural needs. There was information about what people could do for themselves and how this could best be promoted by staff. We heard from relatives that staff promoted people's strengths whilst also taking into consideration their limitations. One person stated, "If I don't feel too good they help me back to bed after my shower and if I am alright they help me dress." Relatives told us, "My [family member] is 38 and they treat [them] like a grown up even though [he/she] can't do anything for [themselves]" and "[My family member] really loves their visits, they do [him/her] the world of good."

We saw cards and emails from relatives and healthcare professionals complimenting the staff for their caring and professional approach.

Good

Is the service responsive?

Our findings

A significant number of people using the service had complex or end of life healthcare needs. People and their relatives (where appropriate), healthcare professionals and senior staff were involved in the care planning process. We reviewed the care and support plans for six people using the service. Records included information about people's medical histories and where required explanations of more complex medical conditions, a timetable of daily care tasks, generic risk assessments, nutrition and medicines details. Important contact numbers of family members and healthcare professionals were listed along with archived communication and daily notes. Where required, staff completed body maps, weight, fluid and nutrition charts, observations and stool charts. We found care plans to be well organised and easy to follow.

The provider assessed whether people had difficulty with reading and accessing information, and care plans were clearly presented in a way which met the Accessible Information Standard. The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS.

Staff demonstrated a good understanding of people's care needs. This included what tasks people needed support with, what they may need encouragement with and how they communicated and expressed their wishes. A member of staff told us the best thing about [their] job was, "Continuity of care. I'm part of the package. It's good for the client and good for me, they get to know me and I get to know them and the family. I can see if the client's well just by looking at [them], even before observations, that's what I really like." Relatives commented, "[Staff] are very helpful and always get my [family member] to do everything [they] can", "[Staff] offer my [family member] choices which [they] can indicate by moving [their] eyes, that is a form of independence" and "They talk to [my family member] nicely and take notice if [they] don't want part of [their] care today."

The provider had protocols in place to respond to any medical emergencies or significant changes in a person's well-being. Staff told us they reported any concerns they had about changes in people's capacity or health status to the care consultants who in turn made a decision as to whether to contact GPs, family members or other representatives involved in people's care. Relatives told us, "When [my family member] came out of hospital they responded well to the extra care that [they] needed", "[My family member] used to get up in the chair but [they] are bedbound now and [their] care has adjusted to this", "[My family member's] needs have increased over time and adaptations have been made" and "[My family member] has deteriorated and [staff] have adapted to it."

Where appropriate, people had the opportunity to discuss their end of life wishes and preferences. Relatives told us, "We have a detailed plan of everything [our family member] would wish", "We have had discussions and have a plan" and "Yes, it has been discussed and there is a record of what my [family member] wants to happen."

Each person using the service was provided with a service user guide outlining the provider's statement of

purpose, service principles and service values. People and their relatives told us, "We have got masses of information, "Yes, we had all the information", "It is a long time ago but yes, we have lots of paperwork about the service" and "We have all the numbers in the kitchen and lots of other information too." The registered manager told us that upon request, the service user guide was available in other languages and formats. The guide also informed people and their relatives about how to make a complaint and to whom. Complaints were logged onto an internal electronic system. This was tracked by the registered manager to ensure complaints were processed in line with the provider's complaints policy.

We asked people and their relatives if they knew how to make a complaint. Relatives told us, "I have nothing to complain about", "I haven't needed to complain", "We have no complaints, quite the reverse" and "I have never had to complain." Where people or their relatives had made a complaint, we asked them if they been dealt with effectively and brought about the desired outcome. Comments included, "I complained last week about late visits, has been as much as two hours and things have improved", "Only niggles nothing formal and they have dealt with them well", "I only complained once informally about a new carer who just wasn't right for my [family member] and [member of staff] hasn't been sent again."

Good

Is the service well-led?

Our findings

We asked people using the service and their relatives whether they thought the service was well managed and whether or not they would recommend it to others. Responses included, "It's very well managed, I am very impressed and I do know the managers", It's very well led and the manager is brilliant, so helpful", "I think it is brilliant I can't praise them too highly", "We are thrilled to bits with them" and "I think they are well led and we have spoken to the manager on a number of times and she was very helpful."

The registered manager was supported in her role by a clinical lead nurse and a team of office staff. She is a board member of the UK Homecare Association and has an extensive employment history in management within the social care sector. Staff told us the registered manager had a friendly approach, was supportive and easy to talk with. Comments included, "Everything is good", "She's brilliant", "It's the best company I've worked for in 10 years" and "The manager is absolutely fantastic, it's a lovely company to work for."

There were systems in place for recording when things had gone wrong. This included obtaining details of an incident or accident and recording what action had been taken in response to this. The registered manager was clear about her registration responsibilities in ensuring the Care Quality Commission (CQC) and other agencies were notified of incidents which affected the safety and welfare of people who used the service. The registered manager had notified us of events that had occurred which meant we had an awareness and oversight of serious incidents and/or safeguarding concerns and were able to confirm that appropriate action had been taken.

The registered manager was aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to the care and support provided.

The registered manager told us that MARs were checked by senior staff before being archived. There was currently no audit overview of medicines which may have made it difficult for the registered manager to monitor any trends in the administration and recording process. The registered manager told us that she would consider implementing a more robust medicines auditing process in the near future.

Systems were in place to record and track staff training and any training that required refreshing. Office based staff were responsible for monitoring DBS checks and nurse's registration status to ensure these were up to date and people using the service remained safe. We were told that office based staff checked all care documentation to ensure relevant correspondence and records were inputted and up to date.

Feedback was obtained through regular telephone monitoring and feedback forms where people were given the opportunity to indicate their level of satisfaction regarding staff competence, attitude and overall performance through a range of performance satisfaction tick boxes. People told us that they were invited to feedback about the service and the staff supporting them. Comments included, "They phone us and check that all is well", "Every now and then we get a phone call to check if everything is going ok", "We get phone calls to check that we are all right and the guy who runs the carers drops in about once a month too" and "Yes, we get a phone call to see if everything is ok and the manager has been round to see us too."

The management team carried out regular spot checks to ensure staff were delivering care to a suitable standard. This included checking that staff arrived on time, wore the correct uniform, communicated well with people and worked in line with the people's care plans. The registered manager told us she visited people in person to introduce herself and complete reviews.

Staff received regular training, supervision and support. We saw staff competencies were reviewed and staff meetings held to share best practice. Staff we spoke with told us meetings were useful and provided them with an opportunity to share information with their colleagues and to keep up to date with any changes. We saw evidence of feedback being used to develop the service where possible. For example; one person using the service had requested that staff didn't wear name badges but instead had 'Team [person's name]' printed on their shirts since they were a small, consistent team who worked closely with this particular person on a 24 hour basis.

The provider was complying with General Data Protection Regulations (GDPR). This included considering what personal information the provider held on people using the service, staff and applicants, assessing who had access to information and whether it was held securely with appropriate consents in place.

We asked people and their relatives if there was anything they thought the provider could do better. Response were as follows; "No, we are really pleased with our carers", "Nothing could be better", "Just timing I think", "Timing and attention to detail", "Honestly they are really, really good" and "I don't think they could improve."