Be Caring Ltd

Be Caring Leeds

Inspection report

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Date of inspection visit:
04 February 2021
07 February 2021
08 February 2021
11 February 2021
17 February 2021
22 February 2021

Date of publication:
21 April 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Be Caring Leeds is a is a domiciliary care agency. It provides personal care to people living in their own houses and flats. At the time of our inspection 300 people were using the service.

People's experience of using the service and what we found
Medicines were not always managed safely. Risk assessments did not always contain the relevant information about people's known risks. There was no overall analysis of incidents and accidents to identify trends or patterns within the service. There were enough staff to meet people's needs. However, timings of visits overlapped which meant staff arrived late or too early for planned visits. Recruitment processes were sufficient. People told us they felt safe with staff and found carers were kind.

Quality assurance systems and audits were not robust as the monitoring in place did not identify the concerns we found on inspection. Although there was a service action plan this did not highlight all of the concerns we found on inspection. Surveys were carried out with people, their relatives and staff to ask for their views.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 4 July 2019).

Why we inspected
The inspection was prompted in part due to concerns received about people's safety and management of the service. A decision was made for us to inspect and examine those risks.

Enforcement
We have identified breaches in relation to regulation 17 and regulation 12.

Follow up
We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Be Caring Leeds

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) 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 Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors, a specialist advisor for governance and two Experts 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.

Service and service type
Be Caring Leeds is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced 24 hours before the inspection site visit. Inspection activity started on 4 February 2021 and ended on 22 February 2021. We visited the office location on 4 February 2021.

What we did before the inspection
The provider did not complete the required Provider Information Return. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. We took this into account in making our judgements in this report. We reviewed information we had received about the service, such as details about incidents the provider must notify CQC about, for example incidents of abuse. We reviewed all other information sent to us from stakeholders such as the local authority and members of the public. We used all of this information to plan our inspection.

During the inspection

We spoke with 14 people to ask about their experience of the care provided and 13 relatives. We spoke with the nominated individual, chief executive, operations manager, registered manager and staff members. We looked at 16 people's risk assessments and 16 medicine records. We looked at eight staff files for recruitment. We also looked at quality monitoring records relating to the management of the service, such as audits and quality assurance reports.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely
• Medicines were not managed safely. Medication administration records (MARs) had not always been signed by staff to indicate medicines had been administered. We were not assured medicines had been given, as there had not been any investigations carried out to check this.
• Medication audits were not effective as they did not identify the issues we found on inspection. We found one person had been given their prescribed medicines patch twice in one week when this was to be given once every week. There was no reason as to why the person had been given two patches and this was not identified on the audit.
• One staff member we spoke with said due to visits taking place at different times one person had been given paracetamol within four hours of taking their last dose. This meant the person had been over administered paracetamol. No harm came to the person.
• We discussed these issues with the registered manager and nominated individual at the inspection and agreed actions would be taken to address the concerns.

This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• Risk assessments were not always person centred to reflect people's individual needs. All care files contained external and internal risk assessments which focused on the person's environment and access into the person's home but not about their individual needs.
• There were no specific risk assessments for how to manage certain physical health needs, such as diabetes, stoma and catheter care.
• Although risk assessments were not detailed, staff we spoke with understood people's individual risks, had received the appropriate training and knew how to support people to mitigate potential risks.
• Systems to improve the safety of the service following incidents were not consistently in place. There was a lack of clear and concise analysis of accidents and incidents to identify any patterns or trends which could be addressed to reduce any apparent risks. In addition, there was no clear identification of lessons learned.

This was a breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations.

Staffing and recruitment
• People and staff told us there were enough staff to meet people's needs. However, visits were not always

on time. One staff member told us they had a visit from 08:30am to 09:30am. However, their next visit was due to start at 9am. This meant they would be late as there was a crossover of visits.
• People told us staff were often not on time. One person said, "When they are late in the evening it means I must wait for my evening meal."
• We looked at the provider's rotas which also showed staff having multiple visits arranged at the same times.
• The provider had recruitment checks in place to ensure staff were suitable to work in a care setting.

We recommend the provider review their staffing rotas and staffing levels to ensure visits are carried out on time.

Systems and processes to safeguard people from the risk of abuse
• The provider had a safeguarding policy and staff demonstrated a good awareness of safeguarding procedures and knew who to inform if they witnessed or had an allegation of abuse reported to them.
• People and their relatives told us they felt safe having staff come into their homes. One person said, "Yes, I think it's a safe service; I feel safe."
• The safeguarding log showed only three out of the 11 safeguarding incidents had been recorded as being closed. The registered manager told us that they would update these records. Following one safeguarding incident we saw dementia training had been booked for the carers and the relative had been provided with feedback.

Preventing and controlling infection
• Staff told us they were provided with protective equipment to use when carrying out personal care in people's homes to prevent cross infection. People we spoke with said staff wore their PPE when attending their homes and all staff were following Covid 19 PPE guidance. There was a good supply of PPE stock in the provider's office and staff knew they could collect more stock at any time.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility
• Quality assurance systems were not robust as the monitoring in place did not identify the concerns we found on inspection. Although there was a service action plan this did not highlight the concerns we found. For example, medication errors.
• During the inspection we found records had not been kept in an orderly manner. For example, some records were in paper format and others on a new computer system.
• Records were not always detailed or accurate. Risk assessments were not always completed for those people with specific health needs and MAR charts had not always been signed for when medication should have been administered.
• There was a lack of oversight of incidents and accidents to identify trends and themes within the service.
• We requested to look at examples of complaints. We saw evidence of the complaints log. However, the responses to these were not provided to us during the inspection. Therefore, we could not be certain that the recorded responses to complaints had been completed to ensure lessons were learned.
• Some people knew how to raise concerns or issues with the service while others found this difficult. One person said, "I don't know who to ask and the new phone system is not as good as it used to be, you used to get an actual person on the phone but you can't any more. I think it's not as good."

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Staff said they were able to raise concerns with the management team. However, they did not always feel sufficient actions had been taken. For example, concerns raised about staffing rotas and communication with office staff.
• Most of the people spoke well of the carers. They said that they did treat the service users well, with care, dignity and respect. Several said that they really enjoyed their carers coming and that they had a really good laugh and joke with them.
• Surveys were carried out with people, relatives and staff to gather their views about the service.
• The Nominated individual told us that meetings were held with team leaders and we were provided

examples of these. However, we did not receive any staff meeting minutes nor management meeting minutes when we requested these as part of the inspection.

Working in partnership with others

• The provider worked in partnership with health professionals when required.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have systems in place to ensure the proper and safe management of medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to ensure systems in place to assess, monitor and improve the quality of the service were being carried out to identify shortfalls and there was a lack of accurate and robust care records.