City of Bradford Metropolitan District Council

Bradford Home Support

Inspection report

Cottingley Cornerstones
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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We carried out the inspection of Bradford Home Support between 27 October and 24 November 2016. On the 27 October we visited Bradford Home Support's offices and made phone calls to people, their relatives and staff on the 07 October and 24 November 2016. At the time of our inspection, there were 350 people using the service. This was an announced inspection which meant we gave the provider 48 hours' notice of our visit.

Bradford Home Support is registered to provide personal care and support to people at home. The service was also known as the Bradford Enablement Support Team (B.E.S.T). The service operates throughout the Bradford, Shipley and Keighley districts.

The service had a registered manager in place 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 '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. The registered manager was present throughout the inspection.

The service was flexible as the number of people that received personal care varied at any given point. This was due to referrals from GPs and other community healthcare professionals. The service also operated 24 hours a day every day and people, relatives, staff and healthcare professionals could telephone the office at any time to receive support.

The service worked in conjunction with a multidisciplinary team to ensure that rehabilitation was fully implemented into people's care packages. This joint working enabled people to regain their independence as quickly as possible.

We found the Bradford Home Support Team completed an initial assessment and care planning process which ensured people's care was detailed and specific to them. People had any personal or environmental risks assessed to keep people and staff safe.

Staff we spoke with were professional and caring and enjoyed working with people who used the service. There were sufficient staff to meet people's needs at all times and the service had a robust method of deployment of staff.

Staff received an induction, training, supervision and performance appraisal for their roles. The service had supported staff through national qualifications. Staff received regular supervision with their line managers and were able to set and achieve their own employment goals.

Recruitment and selection of new staff members was robust and ensured safety for people who used the service.

We found staff were kind and generous. People's comments mirrored our findings from the inspection. Staff told us they respected people's privacy and dignity and ensured that life in their homes was as close as possible to being independent. People had regular opportunities to provide feedback to the service and also have their say in how things operated.

Consent was gained from people before care was commenced and people's right to refuse care was respected.

People were able to share their compliments, concerns and complaints in an open and transparent manner. Where feedback was provided by people or relatives, management would undertake necessary investigations, make changes to their care package and report back to the person who complained.

People's and their relatives' opinions of the care provided was consistently positive. People's medicines were administered, stored and documented appropriately.

The service had a goal of people gaining their independence in six weeks. Evidence from the inspection showed in the majority of cases people were enabled to stay in their own home.

All of the people, relatives and staff we spoke with as part of the inspection told us the service was well-led. They felt the registered manager took time to listen and would take action to make improvements when needed.

People felt management were approachable and had a visible presence in the operation of the service. We found the management conducted a range of checks to assess the standard of care. This included satisfaction surveys where people consistently rated the service as outstanding.

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.

People were protected from abuse or neglect because staff were trained, knowledgeable and not hesitant to act or report on matters of concern.

Comprehensive risk assessments and care plans ensured safe care for people.

Suitable numbers of staff were deployed to provide personal care.

Staff encouraged people to be independent with taking their medicines.

Is the service effective?

Good

The service was effective.

Staff received training during induction and on a continual basis to ensure people received the best possible care. Some training had expired.

The service gained consent from people before providing personal care. People's refusals were respected.

Staff recognised sufficient nutrition and hydration was an important part of personal care and recovery from illness or injury.

We saw links to community health professionals were strong.

Is the service caring?

Good

The service was caring.

People felt staff were kind, compassionate and empathetic to their individual needs.

People were actively involved in the planning and review of the personal care provided.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

People were encouraged to be independent and staff supported people to regain their independence.

The service was able to deliver a package of care quickly to people once they had been discharged from hospital.

A robust complaints procedure was in place and the service demonstrated they were responsive to people's concerns about their care.

Is the service well-led?

Good

The service was well-led.

People's and relatives feedback indicated they felt the service was managed appropriately.

Staff were positive about the management of the service and felt managers were approachable.

The service checked the quality of the care provided and identified if improvements were required.

Outcomes for people who received care were positive in most cases.

Bradford Home Support

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.

The inspection took place on the 27 October and 07 and 24 November 2016 and the inspection was announced. This meant we gave the service 48 hours' notice of our inspection. We gave the service 48 hours' notice of the inspection because the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. We last inspected Bradford Home Support 20 November 2013 when we found it compliant in all areas inspected at that time.

The inspection team consisted of two inspectors.

Before the inspection we reviewed the information we held about the service. This included speaking with the local authority contracts and safeguarding teams. 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. This document was completed and returned to us within the specified timescales.

We looked at how people were supported throughout the day with their daily routines and activities. We reviewed a range of records about people's care and how the service was managed. We looked at three people's care records and three staff files. We spoke with three family members, the registered manager and one support worker. We met one person who used the service, but as we were unable to communicate with them about their care experience, we spoke with their relatives. We looked at quality monitoring arrangements and other staff support documents including supervision records, team meeting minutes and individual training records.

Good

Is the service safe?

Our findings

All of the people we spoke with agreed or strongly agreed that the service was safe. We spoke with ten people as part of the inspection either through a home visit or a telephone call. All people we spoke with agreed they felt safe with the personal care provided, staff had not missed any calls to their home and they were not rushed with care provided by staff. We conducted telephone interviews and home visits with five relatives as part of the inspection. All five relatives told us their loved one felt safe, staff arrived on time and that staff stayed the necessary amount of time to provide personal care. The relatives also confirmed staff had not missed any calls to the person who used the service. We saw the service information leaflet stated, 'We aim to create an environment within your home that is safe and secure.'

There was a strong knowledge by staff and management regarding the principles of potential abuse and how to ensure people were safeguarded should allegations occur. Staff displayed confidence in their knowledge of types and signs of abuse and the action they would take if they suspected or witnessed abuse. Staff we spoke with felt they were able to report another colleague who might abuse a person who used the service. All staff we spoke with were aware of whistleblowing and authorities that they could approach if they needed to report something. The registered manager was clear about their part in managing safeguarding concerns. However safeguarding records were not routinely monitored for trends. Safeguarding was a key part of staff induction and continued training. On the day of the inspection, we saw all support workers and duty coordinators had completed or applied for safeguarding training in the last 24 months. Staff also knew about human rights, discrimination and equality because they received training in the subjects.

People were safe because their risk assessments and care plans reflected their individual risks. We could see people's risks were thoroughly assessed and documented. Risk assessment and care planning often occurred before the person had started with their first visit from the service. For example, the service would ask hospital discharge coordinators and GPs who referred people to the service about specific risks for each person. In the risk assessments and care plans we examined, we saw a comprehensive range of documents. Examples included environmental hazards in the person's accommodation, moving and handling assessments and medicines. The frequency of personal care also reflected people's individual needs. 'We saw risk assessments were updated continually since the service had a system for care workers to report any changes via the telephone to the duty co-ordinators who would then amend accordingly. This meant risk assessments were an accurate reflection of people's current needs.

The number of people who used the service varied from day to day. At the time of the inspection there were 350 people in receipt of personal care in their homes. We found there was an appropriate number of deployed staff that provided personal care and a team of staff who worked in the office location to support staff that provided care in people's homes. When we spoke with the registered manager they told us the service had set a maximum number of people that they could support at any one time and that this would never be exceeded. Staff whereabouts and timing of calls was tracked in the community using portable technology that the staff member carried with them and this was checked by duty coordinators back in the office. Staff were expected to call and message the office if they either exceeded the time they needed for a

single call or had accumulated spare time during their shift pattern. This meant the staffing was tailored to people's individual needs and calls were not cut short or routinely missed. Looking at records in the office we found there were no missed calls.

The service had strong recruitment and selection procedures which ensured suitable, experienced applicants were offered and accepted employment. We looked at eight personnel files. Along with the provider's human resources support, applications and interviews received the necessary scrutiny to ensure candidates were suitable for the type of care provided. Staff we spoke with told us they had to pass a number of stages to be successful in employment. Personnel files contained all of the necessary applicant information. For example, we saw staff had their backgrounds checked, at least two positive references checked and a Disclosure and Barring Service check. This is a check that looks at a person's criminal background to aid staff in decision making when recruiting new people. The registered manager explained applicants would not be accepted for employment if they did not demonstrate their ability to thoroughly learn and accept responsibility for people's safe care in their own homes.

A business continuity plan and emergency procedures were in place if there were events which impeded or prevented calls. When we spoke with staff, they told us they knew what to do in the event of extreme weather such as floods or heavy snow.

Staff and management were confident people who received personal care received their medicines safely. Where possible the person was encouraged by staff to administer their own medicines with staff supervision. Staff only supported the person if their ability to administer the medicines themselves was affected by their medical or physical condition. Where medicines came in bottles and packets staff still encouraged people to be independent in taking it themselves. In a small amount of cases staff were required to intervene to assist the person. Staff explained their response when people refused to take their medicines. They told us they would stay with the person, explain the importance of taking their medicines and see if the person would then take them. If the person continued to refuse to take their medicines, they would report this to the office location for further action.

We looked at medicine records in people's home and found recordings did not have gaps and matched the number of tablets delivered. People we spoke with told us they or their family supported them with medicines.

Good

Is the service effective?

Our findings

All of the people who used the service, relatives and staff we spoke with told us they felt staff were well trained and they knew how to meet peoples' personal care needs. In one example, a support worker had stayed with a person in their house after personal care was delivered because they felt the person was not themselves and they wanted to organise a health professional visit. Care workers and office based staff we spoke with told us they had received training in a number of subjects, including dementia awareness training and had a good understanding of supporting people with their independence and to be able to make decisions for themselves sensitively and professionally.

New staff received effective induction and support to establish their knowledge and skills in their role. The registered manager and home care manager showed us records of staff inductions. The programme allowed the new staff to attend formal mandatory training, shadow experienced staff in the community for two weeks and work with partner agencies to understand what people's needs would be when they took over people's care and support. The provider also used industry-wide training methods for adult social care staff, such as a Diploma in Health and Social Care (Adults) level two or above. At the time of the inspection, we noted some staff had not completed or renewed their manual handling training. The management explained the staff had completed the course before but acknowledge that some were out of date. The registered manager immediately took steps to address this.

Existing experience in staff's prior employment was also recognised so training was individualised. We found staff participated in regular supervision sessions with their line manager and annual goal setting and performance appraisals. We looked at ten examples of supervisions between staff and their manager and saw two supervision meetings, a six monthly and an annual appraisal meeting. This documentation indicated a joint approach between the two parties, recognition of strengths and documented areas for improvement. Weekly and quarterly staff meetings also occurred with a focus on quality as well as information and guidance on changes. Staff were often provided with short presentations or learning and development during the staff meetings, to ensure their knowledge was expanded. An office worker demonstrated the training booking and records scheme to us during the inspection. We could see individual staff training was catered for, the provider knew what upcoming opportunities for training were available and which staff had attended training.

People who used the service received care from knowledgeable and skilled staff which ensured quality care was provided. For example, staff had received training in dementia care, bereavement and how to support a person who had suffered a stroke. When staff visited people who had existing dementia, suffered from bereavement or had a stroke, they were able to provide better personal care because they understood the ways in which people were affected. Staff we spoke with told us if a person they visited to provide care appeared confused they would question why this had developed. Where necessary, staff would call back to the office to seek advice about the person's health condition and also organise calls by community health professionals like GPs and district nurses. This showed us staff were vigilant in supporting people maintain good health.

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 to 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. In the case of Domiciliary Care, applications must be made to the Court of Protection (COP). The service had not needed to make any applications to the COP due to the nature of short term support. We found the service was working within the principles of the MCA, the registered manager understood the legal requirements and what to do if they suspected a person had become unable to make decisions. For example, they told us they would complete a mental health assessment and hold best interest discussions with the person's family.

We spoke with the registered manager about consent, the MCA and best interest decision making at the service. We also interviewed eleven staff where we checked their knowledge and practice in people's provision of consent and best interest decision making. We found consent for start of personal care was obtained at the point of the referral to the Bradford Home Support Team usually by third party organisations. This included for example, GPs, hospitals and occasionally social workers or other health professionals. If consent was not gained at the referral stage consent would be requested at the initial assessment and meeting if the person had capacity. The initial assessment meeting involved documentation being left with the person which contained the service user guide, aims of the service and explanation of the care that could be provided. The person was able to refuse the service if they wanted and this choice was respected by the staff and management. The consent form also flagged to staff to check whether the person had an advance directive to refuse treatment, a do not attempt resuscitation order (DNACPR) or a 'living will'.

People who used the service confirmed they were always asked for consent. People told us their consent was obtained in writing and that staff had explained the reasons for gaining consent. People we spoke with also stated staff always asked for consent before entering their house and also asked for consent prior to commencing personal care. This meant people were able to refuse a visit from the support workers and also had the right to refuse any care during the visit.

Some people who used the service received support with eating and drinking and the preparation of their meals. Staff we interviewed realised the importance of diet in recovery and rehabilitation and had good knowledge about this. Where necessary, the person was encouraged to be as independent as possible in heating, cooking and eating their meals. We found staff also routinely ensured people had access to food and drink when they were concluding their call to the homes. Calls records during the day to people showed they were supported with nutritionally balanced meals of people's choice. Staff told us if people had specific preferences they would update the personal care records so other staff would know what the person liked. This showed staff were conscious of people's decisions and changed planned care in line with preferences and dislikes.

The personal care and rehabilitation service was provided to people for up to six weeks. However, there was an exceptional promotion of maintaining good health and continued support for people who used the service throughout their care and afterwards. The Bradford Home Support Team maintained links with health professionals. At the start of the service, people could be referred to physiotherapists and occupational therapists and the provision of personal care was linked to the support from the multidisciplinary team. Referrals were made quickly to a wide range of other health professionals when it was necessary. This approach meant people could remain in their own home with their family and receive

the appropriate personal care they needed.

The provider maintained accurate records of their effectiveness in the provision of personal care to people who used the service. As one purpose of the service was to prevent hospital admissions and contribute to speedier discharge from hospitals by providing prompt personal care, we examined how responsive the service was to people's needs. We looked at data provided by the service. The registered manager and staff told us a large number of people had become independent of any adult social care at the point they stopped using the service. Most people who had used the service remained in their own home with support from the extension of domiciliary care they had previously received or the start of a long term package of personal care from another provider.

Good

Is the service caring?

Our findings

Many people and relatives we asked gave us feedback about the kindness and compassion displayed by the support workers from the service. Comments from people we interviewed included, "No problems, they are all very good", "They make it so much easier", "They all make it so much easier", "It's so nice to come back home, they really help me to stay here" and, "They really encourage me and it's never rushed."

We interviewed staff to gauge their opinion of whether the service was caring in its provision of personal care. Staff we had contact with were consistently passionate about the caring relationships they developed with people who used the service during the short timeframe of the care provision. Staff demonstrated genuine concern for people's welfare and that they wanted to always be professional in their approach. One staff member explained to us, "We are usually the first person in when someone comes out of hospital so it's important they are not rushed and we can get to know them." Staff were able to give us specific examples about people and how to best support them. Although staff only worked with people for six weeks, their level of knowledge about individuals was high. This showed us the service worked hard at getting to know people and support them with their independence.

The service measured their ability at being caring. A service satisfaction questionnaire was provided to all people who received personal care once a year. The satisfaction survey measured people's reactions to different aspects of care, including whether people felt staff were caring, supportive and their privacy and dignity were respected. We saw scores from people surveyed consistently indicated their opinion was the service was caring with 100% of positive remarks received. This meant people felt the service was consistently caring and a caring approach was sustained over the six week period of provision.

We reviewed people's care to look at their level of involvement in planning, making choices and being able to change the care if they wanted. We found people who had the ability to do so were free to make changes to their care when and if they desired. Where people's conditions meant they were not able to be involved in the planning of personal care, relatives and healthcare professionals were also consulted to ensure the person received the best possible care based on preference and likes. The service also took into account that people often disliked very early morning visits for their personal care. Where possible they arranged calls which accommodated people's requests whilst not interfering with the delivery of care by the support workers for the remainder of their shift. Care documentation showed frequent consultation with people by the office and support workers was undertaken to ensure people felt listened to. At the time of the inspection no one who used the service required an advocate to support them make choices or arrange their care, but there was the ability to have one if a person needed it.

We visited people in their homes as part of this inspection. We found people received personal care which was dignified and respectful. When we asked people and relatives during telephone interviews and face to face meetings whether privacy and dignity was respected by staff during visits they all responded positively. The service offered and delivered person-centred care in a way which helped people to maintain a good level of independence, make choices and enabled people to do as much for themselves as possible. The home care manager told us the service aim for people receiving personal care from the service was to

ensure they could leave hospital as soon as possible, return to their own home and regain the abilities they may have lost as a result of illness or surgery. When we interviewed support workers they told us they had a passion to help people in every respect. They explained they had to encourage people as much as possible and only intervene in people's personal care when the person required the staff member's support. When personal care was provided, staff explained they maintained people's privacy and closed bedroom doors and closed curtains in people's homes. Confidentiality in all formats was maintained, especially with electronic communications.

Good

Is the service responsive?

Our findings

We asked ten people if the service was responsive to their needs. All of these people told us the service met their needs and was flexible to them. Five relatives we interviewed agreed their loved one received personalised care during the duration of the service provided.

We found staff had strong opinions about whether the service was responsive to people's needs. One staff member told us, "As there is no time limit to spend with people, if they require something we can stay with them until they are safe and well." Another staff member commented, "People definitely have their needs met because everything is based around them and what they need."

Support workers and management explained they frequently referred people to external professionals because a person required adaptation of their home or equipment to support the person being independent. When specialised equipment was introduced in people's homes to assist or enable them in the process of personal care staff did not always have the knowledge of how to appropriately manage the appliance. Staff told us someone from the equipment service would be asked to attend the office or person's home and demonstrate the correct functioning of the equipment. This ensured that the service was responsive to people's individual needs and ensured that person's independence.

The service had a complaints policy and procedure. Staff were made aware of this during induction and we observed a copy was easily available for office staff and support workers to access. 11 staff we spoke with knew where the policy was and the steps to follow if a person needed to make a complaint. The policy and procedure contained the information for various staff members regarding their role in listening to and managing complaints. There was the ability to escalate complaints within the organisation if people felt their complaint was not handled well. We viewed the location's complaints register during the inspection and found a low number of complaints which were professionally handled. The registered manager and home care manager's approach to complaints management was that people's concerns should not have to escalate into a formal complaint.

There was an open culture to concerns and complaints about the care at the service. People and relatives were provided with opportunities to share their concerns or feedback through multiple channels. They could telephone, email or write to the service to express concerns about their support workers. The service showed they took internal actions to limit the number of concerns they received from people who used the service. For example, people were encouraged to raise any concerns before they became a complaint. There was an expectation that staff who were delayed arriving for a care visit would call the person and if necessary their relative to inform them wherever possible. When we interviewed support workers they were clear about how concerns and complaints should be handled.

We found regular reviews of people's care were completed by the service's staff. Progress reviews for people's care and abilities were conducted three to four weeks into someone's service provision. We looked at meeting documentation involving support workers where the care of people was reviewed. Staff discussed specific information about people with other care staff to review if changes in care were required.

Staff also discussed progress towards people's goals of regaining their independence or whether referral to other services were needed. We found examples of where a routine review of a person's support had led to more effective care for them.

When people's care was transferred to another service at the end of the six week period relevant information about their needs was communicated and shared with the other service. This was completed by the sharing of person specific information like risk assessments, care plans and referral information to community healthcare professionals. The service could also seek information from relevant external healthcare professionals to provide to the new service provider. This process ensured consistency in the provision of care to the person could be maintained. In limited cases the service had to continue the care for the person beyond the routine six weeks of care. When people's care needed to be transferred to other services at the end of their care package the new service had the necessary information in place to ensure the person's care was coordinated. This showed us the service had taken reasonable steps to ensure the person's change in care circumstances were as person-centred as possible.

Good

Is the service well-led?

Our findings

The registered manager told us the importance being a well-led service was paramount to the functioning of the team in order to provide effective personal care to people. This was necessary because people sometimes commenced care in challenging situations, when people needed to be quickly discharged back to the community or when a person was not used to have people coming into their homes. These factors, coupled with a large number of referrals and the relatively short term nature of a personal care package for people meant there was complexity in the management of the service. Despite these factors, our inspection found the service was well-led and achieved the type of care people in their own homes required.

People we spoke with during the inspection agreed the service was well-led. Relatives were happy with the management of the service and said the process from their view point was smooth and very useful for their family members. Staff were complimentary of the registered manager when we asked. Comments from staff included, "We know what we have to do and we can speak with people if we have a problem", "There is always someone to speak to if we have a problem" and, "We do amazing as a team, we are ace." All 11 staff we interviewed at the office of the service agreed the leadership had a continual focus on improvement, and that there was a willingness to change.

The provider had strong and clear visions about the type of service they aspired to and what they wanted for people who used the service. These were mapped out clearly in different types of literature the provider used. The statement of purpose also clearly stated the aims and objectives of the service. Staff we spoke with knew the purpose of the service and the benefits for people gained from the personal care they received. People and relatives were openly encouraged to contribute to the development of the service being asked their opinion and feedback and regular contact with staff. We were present when one staff member returned to the office and verbally handed over positive feedback from a person they had supported that week. The service maintained strong ties with other departments in the local authority, commissioners and members of various multidisciplinary teams also.

People held high opinions about the registered manager. We spent a portion of our time with the registered manager and home care manager asking questions and examining evidence. We found both to be transparent, approachable and knowledgeable. In all circumstances, the two managers were able to provide evidence that the service was well-led. The registered manager was well respected and liked and had worked at the service for many years. They had oversight of all aspects of the management of the service and were able to provide detailed information about the staff team, people who used the service, areas of strength and those for improvement. When we spoke with staff about involvement of management they told us the two managers had an 'open door' approach, and constantly liaised with staff.

We found the registered manager and provider had robust systems of quality assurance in place to review and improve documentation. We saw evidence for care plan audits to make sure content was appropriate. We saw examples where care plans had been altered to include further information about people. The registered manager told us they spot checked people as part of a quality assurance performance review. We reviewed the adult and community services BEST audit from October 2016. This checked quality matrix was

completed and home care record book was reviewed. For example one person's file identified that it was missing surnames for contacts and key information and second phone numbers were not completed. When we checked this person's file, we found further details had been added. This showed us the service monitored the quality assurance and improved identified areas of concern.

Due to the type of service provided, there were a limited amount of times that the provider needed to legally notify us of certain events in the service. However we found the registered manager complied with the regulatory requirements to notify us regarding the running of the service, and always provided accurate and transparent information.

Providers are required to comply with the duty of candour statutory requirements. The intention of this regulation is to ensure providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment. The registered manager was familiar with the requirements of the duty of candour to people.