Brand Healthcare Services Ltd

Brand Healthcare

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place over two days on the 1 and 2 May 2018. This was the first inspection of the service since it was registered with the Care Quality Commission (CQC) in April 2017.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults and younger disabled adults. At the time of our visit 13 people were using the service.

The service had a registered manager in place. 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.

During this inspection we found two breaches of regulations. This was because there were not systems in place to ensure people were always safe and quality assurance and monitoring systems were not always effective. We also made one recommendation that care plans include details of people's previous life history. You can see what action we have asked the provider to take at the end of the full version of this report.

People told us they felt safe using the service. Risk assessments were in place setting out how to support people safely. Systems had been established to prevent the spread of infection. Although the service did not have a complete record of staff's employment history other checks had been carried out including criminal record checks and employment references. Systems were in place to help reduce the risk of spread of infection, for example staff wore protective clothing when providing support with personal care.

People's needs were assessed before they began using the service. Staff received training and supervision to support them in their role. New staff undertook an induction training programme on commencing work at the service. People were able to make choices for themselves where they had the capacity to do so and the service operated in line the Mental Capacity Act 2005. People were supported to access relevant health care professionals and staff knew how to respond if a person was unwell..

People told us they were treated with respect and that staff were caring. Staff had a good understanding of how to promote people's privacy, independence and dignity. People were provided with the same regular support staff. Systems were in place to ensure people's confidentiality was promoted, such as ensuring records were stored securely.

Care plans were in place which set out how to meet people's individual needs and these were subject to review. They were personalised around the needs of the individuals. The service had a complaints procedure in place and people knew how to make a complaint and complaints had been responded to in line with the policy. Where people received support with end of life care, care plans were in place and the

service worked with other agencies as appropriate.

People and staff spoke positively about the registered manager and systems were in place for seeking the views of people who used the service. People told us the registered manager was approachable and accessible.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. We found concerns with the systems for monitoring that staff attended all appointments and the way medicines were recorded. The service did not always maintain a record of staff's previous employment history.

There were enough staff to meet people's needs and people told us staff were usually punctual.

Risk assessments were in place which set out how to support people in a safe way.

Systems were in place tom reduce the risk of the spread of infection.

Is the service effective?

Good

The service was effective. People's needs were assessed before they began using the service.

Staff undertook regular training to support them in their role. Staff had regular one to one supervision meetings.

People were able to make choices about their care and the service operated within the principles of the Mental Capacity Act 2005.

People were supported to access relevant health care professionals as required.

Is the service caring?

Good

The service was caring. People told us they were treated with respect by staff and that staff were friendly and caring.

Staff had a good understanding of how to promote people's dignity, privacy and independence.

People were supported by the same regular care staff.

We have made a recommendation that care plans include details of people's previous life history.

Is the service responsive?

Good

The service was responsive. Care plans were in place which set out how to meet people's needs in a personalised manner. Care plans were subject to regular review.

The service had a complaints procedure in place and people knew how to make a complaint.

The service was able to meet people's end of life care needs where appropriate.

Is the service well-led?

Requires Improvement

The service was not always safe. Quality assurance and monitoring systems were in place, but they were not always effective. There were instances of poor record keeping.

The service had a registered manager in place and people and staff spoke positively about the senior staff.

Systems were in place for seeking the views of people who used the service.

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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 the 1 and 2 May 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection was carried out by two inspectors 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.

Before the inspection we reviewed the information we already held about this service. This included details of its registration and any notifications of serious incidents the provider had sent us. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We contacted the local authority with responsibility for commissioning care from the service to seek their views.

During the course of the inspection we spoke with three people who used the service and six relatives by telephone. We spoke with six staff; the registered manager, a director and four care assistants. We reviewed four sets of records relating to people including care plans and risk assessments and two sets of medicine records. We checked the recruitment, training and supervision records of four staff. We looked at various policies and procedures and checked the quality assurance and monitoring systems in use.

Requires Improvement

Is the service safe?

Our findings

The service had a safeguarding adult's policy in place. This made clear their responsibility for reporting any allegations of abuse to the local authority and the Care Quality Commission (CQC). The service also had a whistle blowing procedure in place which made clear staff had the right to whistle blow to outside agencies such as CQC if appropriate. Staff were aware of their responsibility to report any allegations of abuse. One staff member said, "If I see anyone who had been abused I would inform my manager." However, the registered manager was not aware of their responsibilities with regard to safeguarding. When questioned by us they said they would only report a safeguarding if the alleged victim agreed to this and they were also unaware of their responsibility to report allegations of abuse to CQC. This lack of knowledge potentially meant that the service might not respond to safeguarding allegations appropriately, thus putting people at risk of potential harm.

The registered manager told us there had not been any safeguarding allegations since the service was registered and we found no evidence to contradict this.

The registered manager told us at the time of inspection the service did not spend any money on behalf of people. Policies were in place about financial abuse, for example, staff were not permitted to buy or sell things from/to people. The policy also stated that if the service did spend money on behalf of people written records had to be maintained of this. This meant the likelihood of financial abuse occurring was reduced.

The director explained the system for motoring that staff attended appointments, that they were punctual and that they stayed with the person for the full amount of time allotted. Staff were expected to log in and out at the beginning and end of every visit they made to a person. This was done electronically with the use of a mobile phone and the information was automatically relayed to the director's computer. This meant they were able to monitor in real time when staff arrived at and left appointments.

We checked the records which showed the system was not been used effectively. We looked at records for the past two weeks which showed for one member of staff in that period they had six appointments and had only logged in and out for one of them. For another member of staff, they had four appointments and had only logged in for one of them. The director told us staff were reluctant to use the system. This meant the senior staff were unable to monitor that staff were arriving and leaving on the specified times so they were unable to check that people's assessed needs were being met.

Checks were carried out on prospective staff before they commenced working at the service. These included criminal records checks, right to work in the UK, references and proof of identification. Two of the four staff files we looked at included a record of the staff's previous employment history and there was a section to record this on the job application form. However, two staff had left this section of their application form blank and there was no other record on the file to account for this. The registered manager told us in both instances they had asked the staff about this and were able to verbally account for this. However, there was no record of this.

The registered manager told us the service supported one person with the direct administration of medicines and had responsibility for prompting another person to take their medicines.

The service had a medicines policy in place which stated, "The medicine administration chart must include all prescribed medicines." The policy also stated that when the service supports people by just prompting them to take medicines, "General support needs should be identified at the care assessment stages and recorded in the service users plan." We found that the policy was not followed for the person who was prompted to take their medicine. All the care plan said was, "Prompt medication" and no further details of what this involved were given. Further, the medicine record for this person did not name the individual medicines the person took. Their medicines were all in a blister pack and the medicine chart simply stated, 'blister pack' even though they were prescribed four different medicines. The registered manager told us because the person only needed support with prompting there was no need to list the individual medicines on the medicine chart.

The medicine charts for the person who was directly supported with medicines were more comprehensive and included details of each individual medicine they took. We looked at the charts for the two month period of March and April 2018 and found they contained no gaps. However, they contained three instances where correction fluid had been used which meant it was not possible to see what the original entry had been. The registered manager told us they knew that correction fluid was not supposed to be used on medicine records and added they had not checked the relevant records and were not aware of the use of correction fluid until we brought it to their attention during the course of the inspection.

Further, on several occasions staff had entered the letter H on the medicine records instead of signing. The registered manager told us this stood for hospital, indicating the person was in hospital and therefore staff had not administered their medicine. However, the records included a key code. Of the four records we looked only one contained the letter H on the key code and the other three did not. This meant it was not possible to see what happened on those days by looking at the medicine records.

The registered manager told us they had not carried out any audits or monitoring of medicines record. There was an audit of care files that checked if people or their relatives had signed consent forms to allow the service to provide support with medicines, but this did not look at actual medicine administration records.

Together, the issues of the registered managers lack of knowledge of safeguarding procedures, the ineffective monitoring of when staff arrived for and left appointments, the lack of a record of staff's previous employment history and the issues with medicine records constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People told us they felt safe using the service, one person said, "My carer is very good. They clean and wash me, change my pads and feed me. I feel very safe with them. They are kind and efficient." Another person said, "I do feel safe with the carers. I am a bit unsteady in the shower and they check I am alright and are very helpful. I can now do more for myself than I used to but it's still reassuring to know they are there. We have reduced the visits as I feel more confident now. They are sensible and that makes me feel safe."

Risk assessments were in place. These included information about the individual risks people faced and about how to mitigate those risks. For example, moving and handling risk assessments were in place which set out what support the person required with various tasks so they were carried out in a safe way. Other risk assessments included the physical environment, falls and medicines. The registered manager told us that at the time of inspection none of the people who used the service exhibited behaviours that challenged the

service and the service did not use any form of physical restraint when supporting people.

Staff told us they had enough time to carry out their duties, one staff member said, "I have enough time." The registered manager told us they did not require staff to travel long distances between clients to help them be on time. People told us that staff were generally on time. They told us staff stayed for the full allocated time, but some said this was not always enough. They added on occasions staff stayed beyond their allocated time and the issue had been raised with the local authority who commissioned their care.

The registered manager said there had been just one missed call since the service became operational. This was because a staff member had to cancel a shift at short notice and the service was unable to find a member of staff to cover the shift. The registered manager said as a result of this episode they had subsequently signed up to an agency who would be able to provide staff to cover a shift if a similar situation arose again.

People told us staff wore protective clothing. One person said, "[Staff member] always wears gloves when washing me and changing pads." A relative said, "They use gloves and leave a box here and they leave the dirty ones in the rubbish." Care plans had information aimed at promoting good personal hygiene. For example, the care plan for one person stated, "Use one washcloth for washing [person] and another for rinsing them." Infection control risk assessments had been carried out at people's homes. Staff were provided with protective clothing including gloves and aprons for use while providing support with personal care. They were aware of how to prevent the spread of infection. One member of staff said, "We use our gloves at all times when we need to carry out any procedure and plastic disposal apron and thorough hand washing and anti-bacterial gel." This meant the service had taken steps to reduce the risk of the spread of infection.

Good

Is the service effective?

Our findings

People told us staff were effective and knew how to support them. A relative said, "My relative is in pain a lot of the time and I think they do understand that. For example, when they move their leg they do it very gently as they feel pain even with a light touch. They help them get onto the bed if they are tired and worn out with the pain. All the carers seem to know what they are doing. They sit and talk with them and always give them a drink, they ask them what they would like."

After receiving an initial referral the service carried out an assessment of the person's needs. This was to determine what those needs were and if the service was able to meet them. The registered manager described the assessment process to us, saying, "I am looking at medication, what can we help them with. I'm looking at swallowing. I look at their culture, their preferences. I look at what equipment they need to aid their movement." They told us where appropriate family were involved, saying, "We involve the family in the assessment." This helped to gather relevant information where the person lacked the capacity to clearly communicate their needs themselves. Records confirmed assessments were carried out.

New staff undertook an induction training programme on commencing work at the service. This included classroom based training and shadowing experienced staff. The registered manager told us this was, "To see what we do (in terms of providing support to individuals)." Records showed new staff also completed the Care Certificate, which is a training programme designed specifically for staff that are new to working in the care sector.

Records showed staff had access to regular on-going training including about medicines, food hygiene, moving and handling, dementia, diabetes and first aid. This enabled staff to develop skills and knowledge to help them perform their role effectively. Staff confirmed they had training, one staff member said in the past year they had undertaken training about, "Health and safety and moving and handling on the computer and I also did some face to face [training]."

Records showed and staff confirmed they received individual one to one supervision from the registered manager. One member of staff said, "I get supervision in the office and at the client's house every two months with [registered manager]."

The registered manager told us that either people prepared their own food or their family members did this. Where the service provided support to people with helping them to eat a referral had been made to the speech and language therapy team who had devised guidelines about how to do this safely. For example, the guidance for one person stated, "Small amount of pureed food at a time via a teaspoon. Stop as soon as client shows any sign of difficulty, a cough, a throat clear, becomes out of breath or drowsy." This meant staff were able to familiarise themselves with the best way to support the person with eating.

We found the service had worked closely with other agencies to help provide appropriate support to people. For example, one person had been referred to the occupational therapy department who had drawn up detailed guidelines about how to support the person with moving and handling. Another person had been

referred to the speech and language therapy team who had developed communication guidelines to use with the person. This meant the service was seeking to be effective in meeting people's needs through the use of specialists with expertise in relevant areas.

Care plans included contact details of people's next of kin and their GP which meant staff were able to contact them in an emergency situation. Staff were aware of what to do in an emergency situation and one staff member told us they had called an ambulance for a person. Another member of staff said, "You call the manager [in an emergency situation] and they will direct you. You don't leave until you hear further instruction from the manager."

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.

The registered manager told us most people had capacity to make decisions for themselves. They said one person lacked capacity and we saw mental capacity assessments had been carried out to determine if people had capacity. We saw where one person lacked capacity their family members were involved in making decisions on their behalf. For example, the person required support to take medicines and the relatives had signed a consent form to agree to this support.

Good

Is the service caring?

Our findings

People told us staff were caring and they were treated with respect. One person said, "[Staff member] is very good and treats me very gently." Another person said, "[Staff member] makes you feel very comfortable and not like a patient. They even offered that if I wanted a takeaway they would go and fetch it for me." A third person told us, "[Staff member] can talk to me about football. I used to work in music and we talk about jazz. They know I enjoy sport and we can chat about that. I wouldn't complain about any of them. I appreciate the staff too as they never seem to be in a rush or make me feel rushed. The other day [staff member] helped me wash and dress and then they went into the kitchen to make me a coffee. They didn't need to do that as I can do it myself but they are all just so helpful. I have a little dog and they put up with him too. They are lovely with my partner too. I have a row of clothes and I choose what I am going to wear but they help me get them on. I think the service is first class." A relative told us, "They [staff] are very good. When [person] gets uptight they are able to calm them down. They talk to them nicely and are so gentle, even more that I am with [person]."

People told us they usually had the same regular staff. One person said, "I always have the same carer. They are excellent and always on time." The registered manager told us they arranged for the same staff to work regularly with the same people. This enabled people and staff to get to know each other and build up good relations. The registered manager added that if a member of staff was away from work they would seek to replace them with a staff member who was already familiar with working with the person who was being supported. Staff confirmed they worked regularly with the same people, one member of staff said, "I work with them on daily basis."

Care plans included information about supporting people with their communication needs. For example, the care plan for one person stated, "[Person] can occasionally spell out words on an alphabet chart through squeezing staff's hand to select the correct letter. [Person] can show a yes by squeezing staff's hand and a no when they don't squeeze." A member of staff said about working with this person, "I use the word chart with the person I work with." The registered manager told us that all of the people using the service when we inspected spoke English as a first language which helped staff to meet their communication needs.

The service sought to promote people's dignity and privacy. A member of staff said they promoted privacy by, "Making sure the door is locked and give her privacy for own space." Another staff member said, "If they want a shower make sure the curtains are drawn and the bathroom door is closed." Care plans set out how to promote dignity in a personalised manner for people when supporting them with personal care. For example, the care plan for one person stated, "Place two large towels, one covering from the shoulders to the waist and the other from the waist to the toes on top of [person's] top sheet. Then carefully remove the top sheet underneath leaving the towels in place. This keeps [person] covered." The care plan for the same person also stated, "Ask [person] their preferences (for personal care). Explain the procedure and continue to talk them through each step of the bath."

Care plans also included information about promoting people's independence, setting out what they could do for themselves and what they required support with. Staff were aware of the importance of supporting

people to be independent and to be able to make decisions for themselves. One member of staff said, "One has to respect the client, their beliefs and their opinions and let them make decisions and choices." Another member of staff said, "Promoting independence is about encouraging them to do things on their own instead of me doing it. For example, personal care, encouraging them to do it for themselves if they can."

Some care plans included information about people's past life history, including details of where they were born and grew up, their employment and their family. This information helped staff to better understand the person which in turned helped them to build good relations with people. However, not all care plans included this. It was only included in one of the four care plans we reviewed. We discussed this with the registered manager who said they would add this information to all care plans and we recommend this.

We found that confidential records about people and staff were either stored in locked cabinets or on password protected computers that only authorised staff had access to. The service had a staff handbook and all staff were provided with a copy of this. The handbook made clear staff were not permitted to share information about people without proper authorisation to do so. This helped to protect the privacy of people.

The service sought to meet people's needs in relation to equality and diversity issues. Shoe covers were provided for staff where appropriate. This enabled staff to wear shoes to promote their safety in a way that was culturally appropriate. Part of the assessed needs for one person was to attend a place of worship and staff provided support with this. During the initial assessment of people it was recorded if they had a preference for the gender of their support staff. Where they expressed a preference, daily records confirmed this was adhered to. Assessments recorded information about people in relation to equality and diversity issues including people's gender, age, religion, ethnicity and sexuality. The registered manager told us none of the people using the service at the time of inspection identified a LGBT but added, "It would not be a barrier (if they did)."

Good

Is the service responsive?

Our findings

Care plans were in place which set out how to meet people's needs. These were of a good standard. The provided detailed information about how to support individuals and meet their needs in a personalised manner. People were generally aware of their care plans and told us it as subject to review. One person said, "They checked through my care plan a few months ago and they said everything was the same." A relative told us, "The care plan has been reviewed and we felt listened to. My relative was included, they really do try. The folder contains all the relevant contact numbers."

Care plans covered needs about moving and handling, communication, personal care, oral care and skin care. Staff told us they were expected to read care plans. When asked how they got to know a person's needs one member of staff replied, "Looking at their care plan and know everything about them."

Detailed daily records were maintained of the care provided at each visit. This meant it was possible to monitor the care provided on an ongoing basis and check it was given in line with the person's assessed needs.

People told us they knew how to complain and felt they were listened to if they did complain. One person said, "I did complain about one of the girls last year. She asked one of my girls to check my handbag for tablets and stood glaring at me when I took my tablets. This was the only time I have ever phoned the office and the manager came out about 2 hours later to discuss it with me. I think she must have told the girl off because I think she left. I have never seen her again."

The service had a complaints policy in place. This included timescales for responding to complaints. However, it contained inaccurate information about who people could complain to if they were not satisfied with the response from the service. We discussed this issue with the registered manager on the first day of inspection and on the second day we noted the policy had been revised to contain the correct information. The registered manager told us the service had received one complaint since it was first registered. Records showed this was dealt with in line with the policy. Staff were aware of how to respond to a complaint. One member of staff said, "If [person] complained to me I would let my manager know."

The service kept records of compliments it had received. We saw compliments from relatives. One relative had written, "The staff were very helpful and kind. They all went above and beyond when caring for my [relative]. The staff were all very respectful of our needs." Another relative wrote, "The staff have been very hard working, on time and very caring."

End of life care plans were in place setting out what support to provide to people and their families. Staff were aware of how to support people with end of life care and the service worked with other agencies where appropriate.

Requires Improvement

Is the service well-led?

Our findings

Although the service had some quality assurance and monitoring systems in place these were not always effective. During our inspection we identified concerns with the recording of medicines, gaps in staff employment history and staff not using the signing in and out of appointments technology. If the service had robust quality assurance systems in place these issues could have been picked up on by the service.

The registered manager told us they carried out telephone monitoring to assess the level of care people were receiving and check people were happy with the service. They told us they phoned each service user once a week. However, the registered manager told us they did not usually keep a record of these monitoring calls and was only able to produce three such records during the inspection. Similarly, the registered manager told us they carried out unannounced spot checks to observe staff, saying, "I want to know the times they [staff] are getting there, I want to see how they perform." But again, as with the telephone monitoring, these spot checks were not routinely recorded, although there were records for some of them. By not keeping records of all phone monitoring calls and spot checks the service missed an opportunity for identifying any patterns of concern that might arise.

Lack of effective quality assurance and monitoring systems and poor record keeping were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Spot check records that were in place showed they checked if staff were familiar with the care plan, if they wore appropriate protective clothing, how they interacted with the person and if they completed all required tasks.

The service had a registered manager in place and staff spoke positively about them. One member of staff said, "[Registered manager] manages the place correctly. They are a good leader." Another member of staff said, "They are a good leader, always there to listen to anything I say to them. Even if they miss your call they will call you back immediately." The service had a 24-hour on-call system whereby a senior member of staff was always available to take phone calls from staff. This meant that management support was always available to staff.

People told us that senior staff visited them, one person said, "I think I have seen the manager but can't really remember but do remember it as a pleasant experience." A relative said, "Just after we started about three weeks ago a lady and gentleman came out to see if everything was ok and to see if the carers were doing a good job. They were lovely. They said if there were any problems to let them know. They were helpful kind and warm." Another relative said of the registered manager, "We find her top notch. She is very responsive and phones to enquires."

The service carried out a survey of people and relatives whereby they were invited to complete a questionnaire about how satisfied or otherwise they were with various aspects of the service. We saw the service was re-active to issues raised. For example, one person raised concerns that staff did not always stay

for the full allotted time. Records showed this was addressed with the relevant staff and the person's care plan was revised to make clear what was expected at each visit. The surveys contained mostly positive feedback, with one person writing, "Brand Healthcare is unique in its service delivery to users. Care workers strive for excellence." We also saw records of a staff survey which contained mostly positive feedback.

Staff told us they attended staff meetings. One member of staff said, "Yes we do [have staff meetings], in the office. Everybody is there to verbalise your mind and state what is happening at your place and see what changes can be done and introduced and put in place to help the service user and the provider too."

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 registered person must ensure that care is provided in a safe way for service users. The registered person must assess the risks to the health and safety of service users receiving care and do all that is reasonably practical to mitigate any such risks including ensuring the proper and safe management of medicines. Regulation 12 (1) (2) (a) (b) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes must be established and operated effectively to assess, monitor and improve the quality and safety of the service provided and to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others. The provider must also securely maintain such records as are necessary to be kept in relation to the management of the regulated activity. Regulation 17 (1) (2) (a) (b) (d) (ii)