Better Home Care Ltd

Better Home Care

Inspection report

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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

Better Home Care is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It is registered to provide a service to older people, people living with dementia and people with mental health needs. Not everyone using Better Home Care received a regulated activity; the Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

This inspection was carried out between 19 and 20 April 2018 and was an announced inspection. This is the first inspection of this service under its current registration. At the time of our inspection there were 32 people using the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People received a safe service. Staff understood what keeping people safe meant as well as to whom they could report any concerns. An effective response to accidents and incidents helped reduce the potential for any recurrence. Only those staff deemed to be suitable following their pre-employment checks that had established their good character were offered employment at the service. There was a sufficient number of staff in post who had the skills and training they needed to provide people with safe care and support. People's medicines were administered and managed safely.

People received an effective service that took account of their independence. People's wishes and preferences were respected by staff who knew what decisions each person could make and how to help people make these. People's care and support plans were an accurate record of their individual needs and any assistance they required from staff. Risks to people were identified, and plans were put into place to promote people's safety without limiting people's right to choose what they wanted to do. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff benefitted from the support, training and mentoring they were provided with and this helped to promote people's safety and wellbeing. Staff understood their roles and responsibilities in meeting people's needs. Systems, including regular spot checks, were in place to help staff to maintain their skills and the standard of work expected from them by the registered manager. People were supported to maintain their health by staff who enabled or supported them to access community or other primary health care services. Staff assisted people to eat and drink well.

People received a caring service. People's care was provided with compassion by staff who promoted

privacy and dignity. People were cared for with respect by staff who did this in an unhurried and considerate manner. People's independence was promoted by staff who encouraged people to make their own decisions about their care. People were provided with information about advocacy services if they needed someone to speak up for them.

People received a responsive service that helped them to have their needs met in a person centred way. Suggestions and concerns were acted upon before they became a complaint. Systems were in place to support people to have a dignified death.

People received a well-led service. Staff had various opportunities including meetings to feedback their experiences and receive updates about the service. Staff were provided with opportunities to develop their skills and the registered manager promoted openness so that people's care was as good as it could be. Staff were supported in their role by the registered manager who listened to what staff said and then put the most appropriate support arrangements in place for each staff member.

Quality assurance, audit and governance systems that were in place were effective in identifying opportunities for improvements. The registered manager was proactive in implementing any actions that were required. People who used the service and their relatives were encouraged to share their views and feedback about the quality of the care and support provided. Their views were listened to, considered and acted upon.

Further information is in the detailed findings below.

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 supported to be as safe as practicable by staff who knew what safeguarding meant.

Staff had been recruited safely and the registered manager had the necessary staff in place to meet their assessed needs.

Medicines were administered safely by staff whose competence had been assessed.

Lessons were learned when things went wrong and improvements in keeping people safe were implemented.

Is the service effective?

Good

The service was effective.

People's assessed needs were met by staff who had the right training and support for their role.

People's independence was promoted by staff who knew how to respect people's decisions.

People were supported to maintain adequate nutritional intake and this helped improve people's health.

Is the service caring?

Good

The service was caring.

People received a service that was kind, compassionate and caring.

People's privacy was respected by staff who were mindful to uphold people's dignity.

People had a say in making decisions about their care and relatives were involved in these when appropriate.

Is the service responsive?

Good

The service was responsive.

People's care was person centred and they could choose those aspects of their care that was important to them.

Concerns were acted upon before they became a complaint.

Appropriate measures were in place to support people with their end of life care needs.

Is the service well-led?

Good

The service was well-led.

The registered manager was aware of their responsibilities and had notified us about events that they were required to do so.

Staff had the support mechanisms they needed and the registered manager had fostered a culture of openness.

People had a say in how the service was run. Quality assurance procedures and audits were in place and these helped drive improvements.

Better Home Care

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 between the 19 and 20 April 2018 and was announced.

The inspection was undertaken by one inspector. We gave the provider 48 hours' notice as the service is small and we needed to be sure they were in. This was also because some of the people using the service could not consent to a home visit or phone call from an inspector, which meant that we had to make alternative arrangements about this.

Before the inspection the provider completed a Provider Information Return (PIR). This is information we require providers to send us at least annually. This provides us with information about the service, what the service does well and improvements they plan to make. We used this information to assist us with the planning of this inspection. We also looked at other information we held about the service. This included information from notifications the provider sent to us. A notification is information about important events which the provider is required to send to us by law such as incidents or allegations of harm.

Prior to our inspection we contacted organisations to ask them about their views of the service. These were the local safeguarding authority and commissioners of the service. These organisations' views helped us to plan our inspection.

On the 19 April 2018 we visited the provider's office and we spoke with the registered manager, two care staff and two relatives. On 20 April 2018 we spoke with five people and a further five relatives by telephone.

We looked at care documentation for four people using the service at Better Home Care and their medicines' administration records. We also looked at two staff files, staff training and supervision planning records and other records relating to the management of the service. These included records associated with audit and quality assurance.

Good

Is the service safe?

Our findings

Staff understood what keeping people safe meant. Staff had regular training and updates about safeguarding people from the risk of any harm. Staff told us about the different types of harm and to whom they could report this to as well as what were the signs to be aware of. Records from the local safeguarding authority confirmed that the registered manager had reported events to them that needed to be reported. One person told us, "[Staff] keep me safe. They arrive on time, stay with me to help me out of bed and they do this very carefully." One staff member said, "If I noticed a person was tearful or withdrawn for no other reason I would call the [registered] manager straight away. I would do this outside the person's home if I had to, to avoid alerting anyone else." People were safely cared for by staff who understood safe systems of work whilst promoting the risks people could take. For instance, by making sure people wore their emergency life line alarms and using mobility aids such as walking frames.

Where people used equipment for their safety such as walking aids, wheelchairs and lifting equipment, staff made sure it was accessible and safe before each use. One relative said, "Since a recent fall my [family member] now religiously wears their life line call bell."

Three of the four care plans we looked at included only limited information about risks to people and how staff should manage these risks. The fourth did not require detailed risk assessments. These risk assessments included those for malnutrition, falls, equipment and skin integrity as well as the person's home environment. Staff were however, able to tell us how they safely hoisted people or made sure their bed rail was safe. One staff member we spoke with said, "I always make sure the bed rail is up when I leave. I also check the person is in a safe position. I only leave the rail down if the person is out of bed." The lack of information put both people and staff at risk of harm. On the second day of our inspection the provider sent to us updated and more detailed risks assessments which gave staff a greater level of information and guidance to manage the risks to people's safety. The registered manager also changed the process they used to monitor risk and make any necessary referrals either directly to the relevant health care professional or through the person's GP.

Where the service determined they could meet people's needs they ensured that there were sufficient staff in place first. We found that as a result of this there were sufficient staff with the right skills that were deployed in a way which supported people's safety. One person told us, "Oh yes, [Staff] make sure I have my walking frame and that I use it. I think I can manage without it but I can't." A relative said, "It is a worry putting [family member's] life in someone else's safe hands but I don't worry as the staff do stay for the time we need them. I have watched their arrival time and it's only ever a bit late if there are traffic issues. The office [staff] always ring me if the [care] staff are running a bit late. It is not a problem as they always turn up."

Recruitment records showed us that staff were subjected to a series of pre-employment checks. These included checks for any potential criminal records through the Disclosure and Barring Service (DBS). The provider obtained two written references as well as evidence of staff's good character and of their qualifications. One staff member told us, "I had to bring my passport and other photographic identity in

before my DBS came back clear." Another staff member said, "I had to sign to say I was fit and healthy to care for people." We saw that any reasonable adjustment for staff were made to help ensure they were safe as well as caring for people safely.

In their initial period of employment staff undertook training for medicines' administration as well as regular updates every 12 months. One staff member said, "I had two observed sessions with the [registered] manager before I was signed off as being competent." A relative told us, "[Staff] sign the medicines form every time they give the medicines." We saw that records for medicines were accurate. Audits were in place and these had identified when staff had forgotten to sign the form. Staff had been reminded of their responsibilities as well as being retrained if they did not improve. The registered manager said, "We have changed the forms now in line with those stipulated by the local authority." We saw that improvements had occurred in how staff completed their records correctly.

Processes and systems were in place to promote good levels of hygiene and prevention of the spread of infection. These included regular training for staff. One relative told us, "[Staff] always wash their hands before any personal care is provided. They wear gloves and their aprons and the girls [staff] tie their hair up. They make sure they leave the house as clean as they find it." The registered manager carried out audits and spot checks to help maintain good standards of cleanliness as well as making sure people's homes were a safe place for them to be cared for in.

Lessons were taken on board when things did not always go as well as expected. For instance, when people had experienced falls or staff had not always recorded that they had administered medicines. The registered manager had alerted the appropriate authorities and taken effective actions including reminding staff to make sure people wore their emergency call life lines. This was as well as working with stakeholders associated with the service and people who were being cared for. CQC records showed that the provider cooperated fully with the local safeguarding authority when any investigations were undertaken. One staff member said, "If we don't report our concerns, nothing would change. It's reassuring to know that when we do report any incidents that they are always treated seriously."

Good

Is the service effective?

Our findings

People's care was provided based on current guidance. Examples included medicines administration in the community and responding to people's wishes to access health care services. One relative told us, "My [family member] has good mental health. [Staff] understand their health condition and make sure everything they do, in my opinion, is to my [family member's] benefit." Another relative said, "I see staff nearly every day. I trust them completely with what they do. I am always called if there are any worries, health wise. I would soon be told by my [family member] if the staff didn't do as they ask, which I am glad to say [family member] never has had to."

Where required, people had the equipment they needed. This had either been put in place before the person started to use the service or as a result of requests by the registered manager through people's social workers or GP. For example, hospital type beds, walking frames and lifting hoists. One person told us, "We couldn't manage at home without all the equipment we now have but it makes my [family member] happy knowing [staff] are skilled at using it." In addition, the provider used an electronic care call logging system which allowed them to monitor if staff were in attendance at people's care calls and at the times expected. We saw that the registered manager was alerted to staff either being late or forgetting to log into a care call. The use of this technology enabled them to take prompt action such as using alternative staff.

A range of training was in place to assist staff with their development. This included subjects such as moving and handling, the Mental Capacity Act 2005 (MCA), food hygiene, autism, epilepsy, dementia care, catheter management and health and safety. We saw that all new staff had undertaken relevant training for the Care Certificate (a nationally recognised qualification in social care), or were in progress of doing this. Where staff were in the process of completing this training we found that support mechanisms were in place such as access to knowledge from experienced staff members including the registered manager. In addition, a programme of planned supervisions was in place where staff could discuss any other training requirements.

The 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. The authorisation procedures for this in services provided in the community are applied for and authorised by the Court of Protection (CoP). We checked whether the service was working within the principles of the MCA.

The registered manager was aware of the correct procedure in applying to the local authority to deprive a person of their liberty. Decisions in people's best interests were always considered in conjunction with, for instance, health professionals, relatives, the person and a social worker. This was to gain legal permission to deprive the person of their liberty and ensure that any restrictions on their liberty were only put in place where the CoP had agreed to this. We found that staff had been trained and they had a good understanding about the requirements of the MCA and its code of practice. People were asked for their consent before

being assisted by staff. One person told us, "It is reassuring to be asked, 'what would you like', 'can I help you with that?' and other questions so that I can make my own decision."

Where people using the service had the mental capacity to make informed decisions for themselves they were supported to do this safely. For instance, people who were at risk of falls were monitored by staff in the least restrictive way such as reminding or prompting the use of walking aids or bed rails. One relative told us, "[Family member] is fiercely independent but [staff] know them so well and understand what they are communicating. [Staff] always respect my [family member's] decisions but give them time to decide." Another relative said, "[Staff] prompt [family member] to eat. I know when they haven't eaten but [staff] are very good at encouraging them." The provider had found that for some people it helped them to eat well if staff ate their own lunch with the person, so this was encouraged. One staff member said, "People do take risks such as not wearing the right clothes in winter or not wearing their correct footwear. We always prompt people to stay safe but it is their choice ultimately what they want to do."

People were supported to eat a balanced and healthy diet as far as practicable. Care plans detailed the involvement of family member's support as well as the assistance to eat and drink that staff needed to provide. For example, for one person staff assisted the person at breakfast and lunch times and a relative provided the support in the evening. Daily care records showed where staff had left people a drink to have later in the day as well as promoting healthy eating. Where people were at risk of not eating or drinking enough we found that measures had been implemented and that these had been successful in preventing further weight loss. A relative said, "I feel confident that my [family member] gets to eat and drink well. Even though they eat less as they have got older [staff] always come up with ideas on how to encourage them to eat. For example, by having a conversation about a meal and then cooking it."

People were supported and enabled to access healthcare services. One person said, "I did have a fall [when staff were not present] and they called a paramedic for me when they arrived. I had to be checked over as I bumped my head." To assist people to have the best possible health care support the provider worked with other organisations such as occupational therapists, GPs, district nurses or tissue viability nurses. One relative said, "With all the help we have had from staff and the community nurse my [family member's] pressure sore they got in hospital has now healed completely."

Good

Is the service caring?

Our findings

People, and their relatives, told us that staff always upheld their privacy and that their dignity was respected. One person said, "I have a female staff member for all my personal care." A relative told us, "[Staff] always give my [family member] privacy. This means a lot to them to have their own time." We saw that care plans were written in a respectful manner and that situations staff needed to be mindful of had been clearly documented. For example, using a different coloured flannel to the person. This was so that staff encouraged the person to be as independent as possible.

Staff told us how they promoted dignity. One said, "I don't just rush in and provide personal care. I take time according to the person's needs, close doors, cover the person as much as possible and give them independence without taking away their skills." Another told us, "I treat each person exactly the same as if they were one of my own family, with dignity, compassion and kindness." One consistent theme that emerged during our inspection was the positive comments from people and their relatives about how good staff were at being sensitive to the person's needs. For instance, one person told us, "[Staff] are always so kind, considerate and they really do care. We have a laugh too which is important." One relative said, "[Staff] are so gentle with [family member]. They do have a laugh too. I feel confident to leave my [family member] in their capable hands." Another person told us, "I am not getting any younger but [staff] make me feel better. I look forward to seeing them every single day. I get on well with them all."

Staff described to us how they made each care call a special event where people were made to feel they mattered. One staff member said, "Covering people's modesty up and only then uncovering bits at a time is important. I would not expect to be left naked waiting for staff to finish. I let people have their private moments in the shower or just talking with them and explaining each stage of care." Where people communicated using non-verbal means we found that suitable arrangements were in place to make sure people felt valued. A relative told us, "My [family member] can't hear but [staff] always take time to make sure they are understood by writing notes." A staff member told us, "It's great to care for people, doing their care but also having a chat, doing a crossword with them or learning some Latin."

All of the staff we spoke with described a working environment where they had time to care for people and meet their needs as well as being supported with any training or additional care-related qualifications. One staff member said, "I am doing my level three diploma in social care. [Registered] manager is supporting me. I have had my shifts changed so that I can complete it before the deadline." Staff rosters were completed in a way which gave staff time to attend meetings and supervision as well as being able to provide care that was unhurried, compassionate and gentle.

The registered manager told us that if any person needed advocacy then they would offer advice about this and the best way to make sure people's rights were upheld. Advice from the provider about advocacy was to help ensure that people have their voice heard on issues that are important to them. It is also uphold their rights and have their views and wishes considered when decisions are being made about their lives. Information about advocacy services was made available to people should they ever have such a need. Advocacy was also provided in the form of various powers of attorney. We saw that lawful agreement had

been obtained for relatives to make decisions for their loved ones such as for health or welfare.

Good

Is the service responsive?

Our findings

People, or those acting on their behalf such as relatives, were involved in determining the level of support they needed. This was as well as information about the person's independence for subjects including washing, nutrition and mobility. The provider told us in their PIR, "During the assessment of people's care needs a life history and preferences are discussed to ensure person centred care." People had control over how and when their care needs were fulfilled and by whom. A systematic approach was taken by the registered manager to implement a package of care based upon people's strengths. One person said, "My [care staff] are ever so good. We do puzzles together. We have a laugh and most of all if I ask for anything extra such as tidying up it is always done and met with a smile." A relative told us, "[Registered manager] came out to see us and they were very thorough in making sure everything was in place and we are very happy with everything."

Care plans included sufficient information for staff to get to know the person. This included information about what mattered to the person, what their life achievements had been and what their preferences for care staff and care call times were. When people wished to make changes to their care this was acted on promptly and to the person's satisfaction. This also included people who communicated in a non-verbal way such as by written notes and information for other stakeholders or health professionals who would also need to communicate with people effectively.

People were provided with information in a format they preferred on how to raise any concerns, complain or make changes to their care. One person said, "Since day one I haven't had any concerns. Everything has gone really well. I couldn't live at home without [care staff] helping me." A relative told us, "We have never had cause to complain. In the early days there was quite a bit of fine tuning to get my [family member's] care right. They are fiercely independent and Better Home Care have respected this but in a way which promotes their wellbeing." When someone had needed to follow the provider's complaints' process, it had been adhered to and the matter had been resolved to the complainant's satisfaction. Another relative said, "It doesn't matter how small the issue is there is always someone who answers the phone in the office. This is really reassuring knowing that you can get the issue sorted quickly." We saw that this had been for subjects including changes to people's care call times or the equipment people used.

No one at the service was receiving palliative care at the time of this inspection. However, the registered manager was aware of the latest guidance for end of life care and they had put processes in place based on this. They told us, "We have provided end of life care. I liaised with the MacMillan and district nurses to have the necessary medicines to make sure people had a dignified death. We also ask people what their resuscitation decisions are and make sure any 'do not resuscitate' advanced decisions are recorded in people's care plans." One relative had complimented the provider by stating in their feedback, "Thank you for all the care and attention you gave [family member]. You were all so kind and caring for [family member] in their last few weeks." Staff were also made aware of any preferences such as what to do when the person died. Where people had required palliative care, support had been provided for relatives and staff. People could be assured that if they needed end of life care it would be based on personalised recommendations for their clinical care in a future emergency in which they might be unable to make or express their choices.

Good

Is the service well-led?

Our findings

We found that in most instances the registered manager and provider had submitted notifications relating to incidents of harm or potential harm to CQC as required by law. However, two incidents where medicines had not been correctly administered had been referred to the local safeguarding authority but these incidents had not been reported to the CQC. This limited our ability to have an accurate and up-to-date record of incidents and to refer these, if required, to the appropriate authorities. The provider had taken appropriate action to make sure people, relatives and staff were safe. The registered manager sent these notifications to us before the end of the first day of our inspection. The registered manager assured us that in future all notifiable events would be reported to us.

A registered manager was 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 registered manager kept the day to day culture of the service and its staff under review. They did this by spot checks to make sure staff were upholding the values set by the provider to always meet people's expectations. One person said, "Only last week the [registered] manager came out to check on [staff]. It is good to have this but we have never had any concerns." A relative told us that some staff had not always been staying for the full amount of time but this had improved lately with no further such occurrences. The registered manager told us that one person required a special type of catheter and that they had rung many pharmacies until they had sourced one. The person told us, "My previous care company would not have done for me what you have done." People were put first and foremost with their care and support.

A range of support mechanisms were in place for staff that included regular supervision, team meetings, shadowing experienced staff and face to face meetings with senior care staff or the registered manager. At staff meetings we saw that staff were reminded of their responsibilities. Subjects covered included accurately completing medicines' administration records and any changes such as people who were new to the service. One staff member said, "The [registered] manager is so supportive. I don't have to wait until my regular meeting with them. I just call them on the phone. It can be a small thing to them but to me it is just having that reassurance. I feel much more confident with their advice." Another staff member told us, "It is so much more supportive here than where I worked before. If I had to whistleblow on poor care here I am absolutely certain I would be supported by [registered manager]." Commissioners of the service fed back to us that policies and procedures for whistleblowing were in place and that concerns were investigated and followed up.

People could be confident that the quality of care that was provided met their needs. All of the people and relatives we spoke with commented favourably about the quality of care that was provided. Comments included, "I would not hesitate to recommend [Better Home Care]"; "[Staff] work so well as a team and it's nice to have such consistently good staff. The new ones soon settle in"; and "There isn't anything that I can think of that could be improved as it's perfect as it is." The registered manager also kept in touch with

relatives by e-mail when reviewing people's care. One example of this was to enable relatives who lived abroad to order groceries their loved ones and these would be collected and delivered by staff so the person could eat fresh food.

We found that the regular monitoring of staff's performance had had a positive impact in helping to make sure they had all the training and support they needed. This was as well as staff using their acquired skills to help people live their life in the best way possible. One compliment sent to the provider by a relative in response to a person's urgent care needs stated, "[Registered manager] and their colleagues demonstrated professionalism and compassion of the highest order. Their work ethic is to preserve independence and dignity for their clients. An outstanding care company that is life changing for all the right reasons."

The registered manager attended a 'registered managers' forum' where good practice was shared on subjects including information from the CQC, technology in care and updates to information about safeguarding. They also worked in harmony with stakeholders including occupational therapists, the local safeguarding authority and, if required, people's GP. We saw that their working in partnership with these organisations had improved people's quality of life, such as by having the right equipment and increased care calls until people regained their independent mobility. One person had written to the provider to reduce their care calls as their mobility was much improved with the support they had received over six months from staff.

The provider took on board learning from incidents including those where people had fallen at home. This included making sure one person wore their emergency call life line which they had previously been reluctant to do. Regular reviews of people's care and how it was being provided had been undertaken. We saw that systems were in place to monitor missed calls and swiftly identify changes in people's care and support. Technology was used effectively to monitor the quality of care provision. As soon as the provider's care call monitoring system alerted the registered manager to risks to people such as a late call, these were acted upon. For example, by using office based, or off duty, staff to cover a care call where there were traffic delays or staff were delayed at another person's home for emergency reasons.

People, staff and relatives had completed quality assurance surveys about the care that was provided. We saw that the majority of people were satisfied with the care they had received. We also saw that where actions had been needed these had been acted upon. For instance, changing the care staff people used where things had not gone as planned. One person told us, "There wasn't anything wrong with my previous staff. We just didn't get on. We now get on ever so well and that makes me feel better." In another situation the staff who undertook spot checks was varied to give a more holistic view of the quality of people's care as well as supporting staff better. People could also contact the provider's office and staff as well as speaking with senior staff during care calls should they ever have a need. A common theme we identified was how well the provider responded to minor concerns and being proactive in preventing these from escalating. People could be confident that their comments about the quality of care were used to identify where improvements were needed. Another common theme was what the provider had done that worked well.