Best At Home Adult Care Private Limited

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## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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

This inspection took place on 26 June 2018 and was announced. We gave the registered manager 24 hours' notice of the inspection to ensure they would be available to meet with us. This was the first inspection of the service since registering with the care quality commission (CQC) in February 2017.
Best at Home Adult Care Private Limited is a domiciliary care agency. It provides personal care to people living in their own homes in the community. The service provides care to a range of people with different needs including older people, people living with dementia, learning disabilities, physical disabilities and mental health conditions. When we inspected the service, there were 8 people receiving domiciliary care. Not everyone receives regulated activity; the care quality commission 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.

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

At this inspection we found that people were protected from the risk of abuse because staff were aware of the type of abuse and action to take if they suspected abuse had occurred.

Risks to people were assessed and staff worked to ensure identified risks were managed safely. Staff were aware of the action to take to reduce the risk of the spread of infection.

There were sufficient staff deployed to meet people's needs and people confirmed they were supported by a consistent staff team.

The service ensured that staff were recruited safety and each staff member had two satisfactory references and a disclosure and barring service (DBS) check.

People received safe support to take medicines where this was part of their assessed needs.

Staff were aware to report any accidents or incidents that occurred whilst supporting people and the registered manager reviewed the outcomes of all accidents and incidents with a view to reducing the risk of repeat occurrence.

People's needs were assessed before they started receiving a service to ensure that staff were able to provide them with effective care.

Staff received an induction when they started work for the service and were supported in their roles through regular training and supervision. The induction process worked in line with the care certificate.

Staff sought people's consent when offering them support. People were supported to have maximum choice and policies and systems in the service supported this practice.

People were supported to maintain a balanced diet where this was part of their assessed needs and encouraged to remain as independent as possible when preparing meals.

Staff treated people with care and kindness. They treated people with dignity and respected their privacy.

People were involved in making decisions about the support they received. They were involved in developing their care plans and received care which reflected their individual needs and preferences.

There was a complaint policy and procedure in place which gave guidance to people on how to raise concerns. People knew how to make a complaint and expressed confidence that any issues they raised would be addressed.

There were effective systems in place for monitoring the quality and safety of the service. People told us the service was well managed.

There were regular staff meetings held to ensure staff were aware of the responsibilities of their roles and kept up to date with service developments. Staff told us they felt well supported and valued by the management team.

People's views were sought to ensure they were happy with the service they received and to make service improvements, if required.

The service had a clear plan in place to allow the service to grow.

## 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 received their medicines safely supported by trained staff members.

People said they felt safe. Staff members could describe in detail how to keep people safe from abuse.

The service assessed people's properties to ensure they were safe for care and support to be undertaken in.

### Is the service effective?

Good

The service was effective.

Staff members received a robust induction into the service.

The service was working in line with the Mental Capacity Act 2005.

Staff members received regular training and supervision to enable them to carry out their role effectively.

### Is the service caring?

Good

The service was caring.

People told us they found all staff members were kind, caring and respectful.

Staff were able to familiarise themselves with people and get to know people's needs.

People received dignified care and support.

### Is the service responsive?

Good

The service was response.

Care plans were person centred and detailed to meet people's current assessed needs.

Care plans to support people to make choices at the end of life were detailed with people's preferences and choices.

Complaints were investigated and responded to promptly.

## Is the service well-led?

Good

The service was well led.

Staff members were very positive about the management of the service.

There were audits in place to monitor and improve the service.

Feedback was sought from people who used the service to monitor and improve what the organisation offered.

# Best At Home Adult Care Private Limited

**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 26 June 2018 and was conducted by one adult social care inspector from the Care Quality Commission (CQC).

Prior to the inspection we reviewed the information we held about the service, including details of notifications submitted by the provider. A notification is information about important events that the provider is required to send us by law.

The provider completed a Provider Information Return (PIR) prior to the inspection. This is a form that asks the provider to provide some key information about the service, what the service does well and any improvements they plan to make. We used this information to help inform our inspection planning.

During the inspection, we spoke with two people who used the service, two relatives, three staff members, the registered manager and the nominated individual. We looked at two people's care plans, three staff recruitment files, staff training and supervision records, and other records related to the management of the service.

We sought feedback from the local authority commission team. They were happy with the service provided and had received no concerns. We used all this information to inform our inspection judgement.

Good

# Is the service safe?

## Our findings

People told us they felt safe when being supported by staff from Best at Home Adult Care Private Limited. One person told us, "Yes, I feel safe. I am well cared for." Another person told us, "Yes, the staff are great, they can't do enough, especially [registered managers name] and [nominated individuals name]." A relative told us, "Yes, [person's name] is safe, if they weren't, you would know about it."

The service had policies and procedures in place to safeguard vulnerable people from abuse. We saw that staff had received training in safeguarding and staff we spoke with confirmed this. Staff told us they were aware of their responsibilities in relation to reporting any concerns they had and told us, "I would go to [registered manager] or [nominated individual], they would absolutely listen to me." Staff could describe signs and symptoms of potential abuse and told us they were aware that they could contact the local authority or the Care Quality Commission (CQC) if they needed to. We saw the service had appropriately made a safeguarding referral to the local authority when a person supported was self-neglecting. A multi-disciplinary meeting was held where actions were agreed to support the person to achieve better outcomes. This meant the service was proactive in raising concerns.

Risks to people were safely managed. People had effective risk assessments in place in relation to moving and handling, mobility, skin integrity and pressure care management and risks of falls. We saw people's risk assessments had been regularly reviewed to ensure it was reflective of people's current needs. Staff we spoke with were fully aware of people's risk assessments and were able to describe the risks that people presented. For example, one staff member was able to describe in detail how they supported a person with a sensory impairment to manage their risk of falls, such as; ensuring the person was wearing their falls pendant when staff leave their property. This meant risks to people were fully assessed and strategies to manage risks were shared with the staff team and control measures implemented to mitigate the risks.

Staff could access people's properties via a key safe. Key safe codes were given to regular staff only, and details kept securely at the registered office. This helped to ensure that only authorised people could enter the property.

We viewed four staff personnel files and we saw that each staff member had the required pre-employment checks in place including two written references and a Disclosure and Barring Service (DBS) check. The service had a recruitment policy in place. This meant there were processes in place to protect people from receiving care from staff who were unsuitable to work with people in isolation in their own home. Furthermore, staff were issued with identification badges and we saw spot checks were completed to ensure staff members were wearing the identification badges when supporting people.

People told us they always received their visit from staff on time. One person told us the staff were always on time and they always knew who was visiting them. Another person said, "They always turn up on time, they let themselves in, they keep me in touch with everything they do. The only time they have been a bit late was this morning but the traffic was bad but they did let me know." A relative said they knew all the staff members and very often the registered manager or nominated individual provided the care. Staff told us

they had sufficient time to provide people with the care they needed. The service offered a minimum of 30-minute calls to ensure the staff were not rushed and could meet people's needs. Rotas showed that staff were generally assigned to supporting the same people and travel time reflected between the calls to ensure staff had the required time to travel between scheduled visits. This meant the service was proactive in ensuring they provided the correct level of care within the allocated time frame.

We saw medicines were safely managed. Staff were given medication training from a pharmacist and completed a number of shadow shifts to ensure they were competent to administer medication. There was no maximum number of competencies to undergo, the registered manager told us that they continue until they and the staff member felt competent enough to administer the medication alone.

There were two people using the service who received support with their medicines. We saw each person had a medicine risk assessment which considered people's capacity and compliance, any visual impairments that may prevent people from reading labels, if the person was aware they needed to take their medicine and if they were able to physically take the medicine themselves. People were then scored on the level of assistance they required. Both people required level two support with medicines which meant that a staff member needed to prepare the medicines for immediate administration. This meant the service was identifying appropriately where people needed help and not taking away the independence of those who could take the medication independently or with prompting.

Staff told us any concerns with storage or labelling of medication were reported to the manager. We saw medication administration records (MAR) were kept for people who were being supported with medication. This included recording of the date, time and the medication taken and was signed by the staff member that had administered the medication. One staff member we spoke with told us "We're aware which people need to be supported with medication as it's written in the care plan." This meant staff were clear as to what was expected of them when supporting people with medication. We checked the stock levels and MAR charts for one person and found stock levels were correct and the MAR charts were fully completed.

Medicines were audited monthly. No areas of concerns had been raised on the previous three months audits.

Staff we spoke with told us they had access to personal protective equipment (PPE). We saw stocks off PPE at the office and people and staff told us there were additional PPE kept in people's properties. Staff members completed training in infection control and food hygiene. This meant that people and staff were protected against infection control risks.

The service assessed each person's property prior to agreeing to provide personal care to the person. This looked at the properties external lighting, pathways, windows and locks. Internally, the service assessed if the property was in a good state of repair, hygienic, had hand washing and waste facilities and for any infestations as well as ensuring there was enough space for people who required moving and handling. This meant the health and safety of people and staff were assessed to ensure that the property was safe and fit for purpose.

A fire risk assessment was carried out in each person's property and any concerns were identified and reported to the fire officer or local authority. The service looked at fire hazards and checked smoke alarms and detectors were in good, working order and used a checklist at the end of each visit which ensured the gas was turned off and electrical items not in use unplugged. This meant the service was ensuring the health and safety of both people and their staff members.

The service had systems in place for the reporting and recording of any accidents and incidents that occurred. Staff were aware of the provider's accident and incident reporting procedures. The registered manager maintained a record of each accident and incident that had occurred, which included details of the action that had been taken in response and any further follow up action taken to reduce the risk of repeat occurrence.

Good

# Is the service effective?

## Our findings

We saw staff received an induction into the service. The induction started at the office where staff were invited to meet the registered manager and nominated individual. The induction was then spread over four days where the new staff members covered an introduction to the service, learn about their role and complete mandatory training. Day two and three were spent completing further training and day four entailed looking at peoples care files and risk assessments, practising recording in daily notes and practical moving and handling training.

The induction training is linked to the care certificate. The care certificate is an identified set of 15 standards that health and social care workers adhere to in their daily working life. New staff shadowed experienced carers for a number of days until they were deemed competent to work alone. All staff we spoke with confirmed they had received an induction and the opportunity to shadow more experienced staff before working alone. One staff member told us, "I got an induction, a very good induction. Until I did the training, I was supervised visiting clients on many occasions before I worked with them on my own, I got to know them well."
The registered manager told us they encouraged staff members to spend time getting to know the people they supported. The induction process took 12 weeks to complete and there was a knowledge check at the end of the induction to ensure staff were able to demonstrate what was expected of them. This meant the service was ensuring that induction was effective in supporting staff members in their job role.

We saw staff had been trained in health and safety, moving and handling, safeguarding, dementia awareness, the safe administration of medicines, food hygiene, nutrition, mental capacity, infection control and managing challenging behaviour. After training, staff had their competency assessed with multiple choice questions and answers to check their understanding of the training.

Staff we spoke with told us they thought the training was good and that they were able to access other courses such as level two diplomas in health and social care. We saw the registered manager had established links with the local authority to enable themselves and staff members to access the local authority training platform.

People and their relatives told us they felt staff were competent in their role. One person said, "I am very well cared for. They [staff] know what they are doing."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who use the service and 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. We checked whether the service was working within the principles of the MCA 2005.

We checked whether the service was working within the principles of the MCA. People told us staff members

sought their consent prior to supporting them and that they were always informed of what task the staff were completing during the visit. Staff told us they had received training in MCA and knew how to ensure they gained consent before supporting people. One member of staff told us if they noticed a change in a person's cognition, they would report it to the registered manager.

We saw the registered manager had raised concerns around people's mental capacity with the local authority which then led to the person's capacity being formally assessed. This demonstrated people were being supported in line with the MCA and staff had a good knowledge of how they should support people in line with the MCA.

We saw initial pre-assessments had been completed for people receiving personal care from the service. Part of the initial assessment was to request consent to provide personal care and keep information about the person. Staff told us when a new person begins to use the service, they are happy with the information that is provided to them and that they get to introduce themselves to the person to read the care plans and risk assessments. All assessments we viewed were fully completed and contained detailed information to enable the service to support people effectively.

People told us staff sought their permission to care for them, one person said, "Oh yes, they always knock on the door and let me know that they are here, they are very polite and I always know what they are doing." A staff member told us, "I always ask permission to enter a property and let the person know what I am doing to help them."

When a person's relative had consented on their behalf to care their and support, the service had ensured their relative had the legal right to do so. We saw one person's care had been consented to by a relative even though the person has been assessed as having capacity. However, we determined this was because the person had a visual impairment and there was additional information contained to confirm the person was in agreement with their care and support plans but had asked their relative to sign on their behalf due to the visual impairment. This meant that the service was working in line with the Mental Capacity Act 2005.

Staff confirmed they received regular supervision. We saw supervision sessions were held quarterly and the records we looked at showed; professional boundaries, relationships, personal life support, staff members work issues, supervisors feedback. development needs and agreed actions had all been discussed. Staff members told us they could raise any concerns in supervision and felt they could ask for additional supervision at any time.

People had access to a range of healthcare services when required in support of their health. Most people told us they were able to manage their own healthcare appointments, or had the support of relatives to do so. However, where people required support the registered manager confirmed staff were available to assist when needed. Staff also told us they monitored people's health and would seek to contact healthcare professionals if they had concerns about someone being unwell. This was documented in the daily notes in people's care files.

Where people were supported with meals, we saw there was detailed information in relation to people's likes, dislikes and allergies. People were encouraged to assist in making light snacks and staff had received nutrition training from a national food supplier. People were supported to maintain a balanced diet where this was part of their assessed needs. Peoples care plans contained details of support they required with eating and drinking, for example, one person's care plan stated they needed supervision when making hot meals and staff were to ensure food was cooked and equipment was turned off when not in use. This meant the person could continue to cook independently and stayed safe.

Good

# Is the service caring?

## Our findings

People we spoke with said all the staff had a kind and caring attitude. One person told us, "I am very happy with the service, I have got two smashing staff members and they are great. I have been very lucky with my carers, I couldn't be treated better if I was the queen. They even sent me flowers and a card on my 90th birthday." A relative told us they found staff to be kind and caring and that the registered manager and nominated individual were hands on and always jolly.

As the staff team was small, there was continuity of staff for all of the people using the service which meant people were familiar with their team and this supported relationships to develop. If there was a change of the regular staff, people told us they were always informed and the registered manager or nominated individual were doing visits to assist people too.

People told us staff treated them with respect. One person told us, "The staff are very helpful, courteous and jolly. They are always on time and always have my best interest at heart. Can't fault anything about the service. Made my life a lot easier. Everything is perfect and I mean it. Just brilliant and excellent service. Very happy with care given to date by both [registered manager] and [nominated individual]. Compassionate, caring and a pleasure to have around"

Staff members told us they enjoyed being able to get to know people. One staff member said, "The best part is that we can get to know the people we support rather nipping in and out."

We saw people's preferences, likes and dislikes were recorded in their care file. This information was captured as part of the initial assessment. This included whether they preferred a male or female staff member.

People told us staff members supported them how they wished to be supported. One person said, "They [staff] help me with my meals, they visit me four times a day, they help me to wash. I can choose to do what I want. I have recommended this service to a friend."

Staff members told us they closed doors and curtains when personal care was being provided. All staff members were dignity champions and they were aware of the ten 'dignity do's' to promote people's dignity. This meant that staff members were supporting people in a dignified and respectful manner.

Good

# Is the service responsive?

## Our findings

People told us they had been involved in developing their care plans and received personalised care which reflected their individual needs and preferences. A relative told us that an assessment had taken place of the persons needs prior to the service providing support and we saw the assessment was used to formulate care plans.

Care plans contained detailed information and confirmed what support people required with communication, nutrition and hydration, personal care, social and cultural needs, mobility and health and safety. For example, we saw detailed records of how staff should communicate with one person who was hard of hearing. The care plan stated staff needed to shout loudly to express they had arrived in the property, speak clearly into the persons ear and pat the persons back. We saw that care plans relating to nutrition and hydration discussed what assistance people needed with making meals and snacks and preferred diets.

People and their relatives told us they had been involved in their care planning and one person told us and we saw they had completed their own section of the 'About me'. This gave information on people's spoken language, likes, dislikes and what was important to them. It also contained additional information on the help people required such as eating and drinking and personal care and communication. A laminated version of this document was kept in each person's property and was used as an information tool for hospital staff should a person need to be admitted. This meant care and support had been planned for capturing people's choices and preferences and information formulated that could be shared with other professionals to help people to be cared for.

Care plans also included consideration of any support people required support in regard to any protected characteristics under the Equality Act 2010. The registered manager told us that none of the people using the service at the time of our inspection had diverse needs and this was confirmed by the people we spoke with.

Care plans were reviewed monthly or more often if required. We saw people were encouraged to contribute to the review of their care plan and there was documented evidence where there was a change in a person's care needs, a meeting was held to complete a new care plan which reflected the current assessed needs. We also saw there was a six-week review in place for anyone newly receiving care from the service. This meant the service was monitoring peoples care and support and ensuring people's current needs were reflective in the care plan.

We saw a summary of tasks were recorded in each person's care file which confirmed the agreed schedule of visits and what was expected from the staff members. For example, for one person, they had recorded. 'Morning visit, turn heater on in bathroom, assist with personal care and clean commode.' This was used as a quick glance guide for staff members to be aware of people's needs.

We saw there was a will and funeral plan in place which confirmed any advanced decisions made by the

person or their legal representative. The plan confirmed the type of funeral the person wanted and where they wanted to be cared for as they approached the end of life. At the time of inspection, the service wasn't supporting anyone who was nearing the end of life.

The service had a complaints procedure in place and people told us they knew how to make a complaint. There had been one complaint made since the service was registered, regarding a call made which was too early. The service apologised and met with the person and their family and shared outcomes of the complaint. This meant that complaints were investigated and responded to promptly.

There were a number of compliments received by the service which included, "[Staff name] goes beyond the duty of care, she brought a book written by my wife's favourite author and read to her, so caring and compassionate, friendly and professional. " " [Person's name] was full of praise and said [staff member] had healing hands, she's caring, compassionate and kind."

Good

# Is the service well-led?

## Our findings

People and their relatives spoke positively about the way in which the service was run. One person told us they found the registered manager and nominated individual to be very proactive and always at the end of a phone. Staff members we spoke with told us, "I would give them [registered manager and nominated individual] 10 out of 10 for what they do, they are really appreciative and they have a good approach. I had been at the service for two months when they sent me a card saying thank you and said I was doing well and included some comments from people using the service." Another staff member said, "I enjoy working for them, they are like family."
A professional we spoke with told the service was always responsive and communications were open and transparent.

The service had a registered manager in post who demonstrated a good understanding of their responsibilities under the Health and Social Care Act 2008. They were aware of the different events they were required to notify the Care Quality Commission (CQC) about and records showed they had submitted notifications where required, in line with regulatory requirements. The provider's nominated individual was also actively involved in the day today management of the service and the registered manager told us they supported each other.

The management team were committed to ensuring staff felt valued in their roles. For example, staff had received thank you cards and were supported to take on further training to enhance their roles.

We saw regular audits took place to monitor and improve the service. Medication audits were completed monthly which checked the recording of medicines and that medicines had been administered and signed for. Training was audited by staff members giving feedback on the training and checking their understanding of the course. Care plan audits checked the document was in place and valid. Recruitment audits observed that appropriate recruitment methods were followed. This meant the management was consistently monitoring and looking to improve their service to keep people safe and gave the registered manager and nominated individual oversight.

A mixture of announced and unannounced spot checks were completed with staff which recorded the punctuality of the staff member and tested their knowledge of the person's care plan and that they were involving people in their tasks. Initially spot checks on new staff members were every other week and then became less often as staff progressed in their role. Spots checks were recorded. This meant the service was assuring itself that staff members were competent in their role and were aware of what was expected of them.

The service had a business continuity plan in place to give guidance on what to do in the event of power failure, fire or another event that could adversely affect the running of the service. There were also policies in place for safeguarding, recruitment of staff, infection control, end of life and whistle blowing.

We saw regular staff meetings were held with the staff team and the operational team. There were

discussions documented on the support people required, mental capacity and safeguarding as well as plans at operational level such as recruitment and retention of staff and plans to expand the service in different geographical areas. Additionally, the service had invited a lead from the environmental health team to seek advice on food standards in domiciliary care.

We saw the registered manager communicated to the staff team via text message and email. There were communication logs kept between staff members and the office which documented concerns such a medication queries or an unsafe property. We saw where these concerns had been raised, they had been acted on promptly.

The service had been part of a monitoring visit by the local authority which they scored a rating of green overall with them being 91% compliant in care planning, 100% compliant in training, dignity in care and management.

The service had its own self-assessment tool linked with the regulations of the Health and Social Care Act. The outcomes were rag rated; red, amber or green in terms of compliance with the regulations. We saw the management had rated themselves green for meeting nutrition and hydration and for premises and equipment and amber for the remaining regulations. However, this self-assessment tool was completed when the service commenced and we discussed this with the registered manager. Following on from this inspection, we are confident that most of the regulations met were now triggering green. The service was due to assess themselves against the regulations again. We will review this at our next inspection.

We saw the service had obtained feedback from the people they supported. The results showed that of the service users, six responses had been collected and all said they found the staff team professional, caring, courteous and knowledgeable. All staff were on time and all provided good quality, high standards of care. This meant the service was gaining feedback to monitor and improve what they offered.

The management had a clear plan to grow their business and had worked hard to ensure requirements were in place such as; trained staff, processes for planning for recording care and support and policies and procedures prior to offering support to people.

The service has planned a person-centred workforce development plan which includes ensuring staff members were trained to the highest standards and that the home visit call allowed staff the time to communicate with people as well as being able to care and support them with their assessed needs. The goal of the service is to ensure the care and support is as person centred as it can be and includes people in all aspects of their needs being met.