Bio Luminuex Health Care Ltd

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Inspection report

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Date of inspection visit:
20 June 2018

Date of publication:
20 July 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out this announced inspection on 20 June 2018. This was the first inspection since the provider registered this location in July 2017.

Bio Luminuex Health Care Limited is a domiciliary care service. It provides personal care to people living in their own houses and flats in the community. At the time of the inspection the service was providing personal care to 17 older people and people with physical disabilities in the London Borough of Newham.

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 told us that their care workers were kind and caring. People received support from consistent staff who spoke their preferred languages. The service carried out regular telephone monitoring and reviews to check people were satisfied with their service.

The provider carried out detailed assessments of people's care needs and used these to draw up detailed care plans which were reviewed regularly. Accurate records were maintained of the care people received. These showed that care was delivered as planned, but sometimes lacked detail on how people's wellbeing varied from day to day and the interaction they had had with care workers.

Staff were aware of their responsibilities to report abuse and had received training in safeguarding adults. The service had suitable measures for responding to suspected abuse. The provider operated safer recruitment measures to ensure that care workers were suitable for their roles.

The provider carried out comprehensive and detailed assessments of risks to people who used the service. There were detailed plans for how to mitigate these risks, including how to support people to transfer safely. People told us that their care staff were punctual and reliable and when two care workers were required to support a person safely this was in place. There were procedures in place to record incidents and their follow up, and to ensure that when people complained about the service appropriate action was taken in response to this. People told us they were confident speaking with managers if they needed to make a complaint.

The service carried out assessments of people's capacity if there were concerns about their ability to consent to care. We found that when people had capacity but were unable to sign for reasons of disability the provider was not able to evidence how they had consented to their care. We have made a recommendation about this.

Managers checked that care workers were competent to administer people's medicines safely. There were

detailed assessments of the support people required with their medicines but these lacked detail on why people took medicines and what the possible side effects of these are. Care workers maintained accurate medicines recording charts which were checked regularly by managers. Care plans were detailed about the support people required to eat and drink well and records showed that this was taking place.

Care workers received suitable training and supervision to ensure that they were suitable for their roles, including regular spot checks by managers. Managers had detailed systems of audit to make sure people received good quality care and had a clear plan for continuing to develop and improve the service.

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.

Care workers had training in safeguarding adults and were confident about their responsibilities to report suspected abuse in line with the provider's procedures.

The provider carried out comprehensive assessments of risks to people's safety with suitable personalised risk management plans.

The provider operated safer recruitment measures to ensure staff were suitable for their roles.

Medicines were safely managed and managers carried out monthly checks to ensure this continued.

Is the service effective?

Good

The service was effective.

The provider carried out detailed assessments of people's care needs. This included identifying the support required to make sure people had enough to eat and drink.

Care workers received suitable training and supervision to ensure they had the right skills to carry out their roles.

The provider assessed people's capacity to make decisions about their care, but did not always have suitable evidence of people's consent when they were not physically able to sign a care plan.

Is the service caring?

Good

People told us their care workers were kind and caring.

The service met people's communication needs by ensuring they were supported by people who spoke their language.

There was information on people's plans about their needs and preferences and how care workers could support independence.

People consistently received care from the same care workers.

Is the service responsive?

Good

The service was responsive.

People had care plans which met their needs and were reviewed monthly in order to ensure this continued. Reviews were also used to check whether there were any issues of concern.

Care was delivered in line with what was planned, although logs of care sometimes lacked detail about people's wellbeing and interaction.

People were confident raising concerns with managers. There were appropriate measures for responding to complaints and ensuring people were happy with their resolution.

Is the service well-led?

Good

The service was well led.

Care workers told us they felt well supported by their managers.

Managers had systems of audit and monitoring to ensure that the service met people's needs.

There was a clear action plan in place for improving and developing 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.

Why we inspected: This was a routine comprehensive inspection. We aim to carry out a first ratings inspection within 12 months of a location being registered to provide a regulated activity. We were not aware of any complaints, concerns or safeguarding allegations regarding the service.

This inspection took place on 20 June 2018. We gave the service 48 hours' notice of the inspection visit because it is small and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. The inspection was carried out by a single adult social care inspector.

Prior to carrying out this inspection we reviewed information we held about the service, including checking notifications of significant events the provider is required to tell us about. We checked the provider's status with Companies House. We asked the provider to complete a provider information return (PIR). This is a document which asks the provider to tell us what they think is working well and their plans to develop and improve the service. We also requested the views of a contracts officer from the local authority about the service's performance, but did not receive a reply.

In carrying out our site visit we spoke with the director, registered manager and co-ordinator. We looked at records of care and support for four people who used the service and records of medicines management for the two people the service supported with medicines. We looked at records of recruitment and supervision for four care workers. We also looked at overall records of staff training and supervision, internal audits and policies and procedures. Following our site visit we made calls to staff members and people using the

service, and spoke with four care workers, one person who used the service and three relatives of people who used the service.

Good

Is the service safe?

Our findings

The provider had procedures in place to safeguard people from abuse. This included a policy which outlined staff responsibilities if abuse was suspected. Care workers received training in safeguarding adults and were able to describe possible signs of abuse and their responsibilities to report these. Care workers told us they thought their managers would take this seriously. Comments included, "They would take the action seriously if anything was amiss" and "Yes they do take action."

As part of their initial assessment the provider assessed whether people would be able to respond to abuse and whether risk factors such as isolation might make a person more vulnerable to abuse. This was used to determine the level of monitoring people received from senior staff members. There had not been any allegations made against the provider's staff, however the provider had appropriately reported a concern about neglect by a third party. Managers carried out a monthly check to ensure that any safeguarding matters had been appropriately reported.

The provider carried out comprehensive assessments of risks to people using the service. These included important factors such as the person's home environment and risks relating to health conditions and conditions such as diabetes and dementia. The provider assessed people's abilities to mobilise and whether they were at risk of falls. When people required support to make transfers there were clear and detailed plans for care workers to follow, including the use of equipment, risks from clutter or a confined environment and highlighted poor practice which should be avoided. Risk assessments were clear about how people's abilities and risks may vary depending on their current health. Where specialised equipment such as hoists and hospital beds were in place the provider had checked that these were safe and had been serviced. Risk assessments were clear about the risks from cross infection and how these needed to be managed, for example by ensuring care workers washed their hands and wore appropriate personal protective equipment (PPE).

Moving and handling risk assessments were clear about how many care workers were required to support a person to transfer safely. When two care workers were required logs of care showed that this was in place.

People and their families told us that their care workers were punctual. Comments included, "They always come on time" and "Yes, she arrives on time, she's very much on time." Care workers told us that they had enough time to travel between appointments and arrive on time. We did not see any evidence of missed or late visits. The provider told us that at present they did not have an electronic call monitoring (ECM) system in place but that this was not a risk as people or their families were able to call the office if a care worker did not arrive, which we confirmed by checking care plans. The provider told us they were undergoing training on implementing an ECM system.

The provider carried out checks to ensure staff were suitable for their roles. This included obtaining proof of identification and the right to work in the UK and obtaining a complete work history and references from previous employers. Where necessary these showed satisfactory conduct in previous health or social care employment. The provider checked that they had obtained two references but did not specifically check

that they had evidence of satisfactory conduct in previous health or social care employment. Before starting work the provider carried out checks on staff with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions. The provider maintained a matrix to ensure that they carried these out every three years, as required by their contract with the local authority.

Medicines were managed safely. One relative told us, "There are never any problems with the medicines." The provider supported two people to take their medicines and carried out a comprehensive assessment of people's medicines and needs and the level of support people required from care workers. Although the provider had an up to date list of people's medicines this lacked detail on what the medicines were for and any specific side effects which care workers should be aware of. We looked at three months of medicines administration recording (MAR) charts for both people and saw that these were fully completed and checked by managers to ensure that these were correct.

Managers carried out a monthly review of people's medicines, including checking whether care plans were still accurate, whether MAR charts were appropriately completed and whether care workers had received training. Where care workers administered medicines, managers had assessed their skills to ensure they were able to do this safely.

The provider had a system in place for recording incidents, including recording who was involved and actions that were taken in order to resolve this. At the time of our inspection no incidents had been recorded, and managers carried out a monthly audit of records to ensure that this was correct.

Good

Is the service effective?

Our findings

The provider carried out a detailed assessment of people's needs before they started to receive care. A care worker told us "They put in everything they get, they assessed the service user first. Everything is there to follow." The assessment included an overview of people's needs, any medical conditions and relevant history and information on people's needs relating to moving and handling, continence care, nutrition and hydration, personal hygiene and skin integrity. There were frameworks for assessing people's psychological and cognitive functions and people's mental health.

Care workers received a detailed induction on joining the service. This included a review of the aims of the organisation and their policies and procedures. Care workers completed a Care Certificate as part of their initial training. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It's made up of the 15 minimum standards that should be covered if a staff member is 'new to care' and should form part of a robust induction programme. This included training in areas such as safeguarding adults, moving and handling, health and safety, first aid, mental capacity and basic life support. In addition to mandatory training some staff had received additional training in areas such as pressure sore care, dementia awareness, autism and epilepsy. The provider told us that this varied based on people's roles. All care workers were working towards or had completed at least a level two qualification in health and social care. The provider maintained a matrix to ensure that care workers received refresher training in line with their requirements.

Care workers were positive about the training they received. Comments included "Our training is kept up to date and if there's anything we have to know they let us know", "It's useful" and "When I need any training I inform the manager so they arrange it."

Care workers received supervision every two months, and managers maintained a matrix to check that this was taking place. Supervision was used to discuss key areas such as the job role, safeguarding adults, recording and reporting and to check care worker's understanding of infection control and to identify training needs, which was used to agree a personal development plan. Care workers also received a yearly appraisal, which was used to assess the worker's understanding of their key responsibilities and duties, give feedback about their performance and identify objectives for the coming year.

People and their families told us they got the right support to eat and drink. Comments included "They make sure he has enough to eat" and "They help with food and leave a drink". The provider carried out assessments of people's needs, including identifying people at risk of malnutrition and checking who was responsible for meeting these needs. Where meal preparation formed part of people's care plans logs showed that this was taking place.

People's plans included information about the support they received from health professionals to stay healthy and recover skills that they had lost due to injury and illness. This included information on how people's medical conditions impacted on their daily living skills. There was evidence of joint working with

these teams. For example one person was receiving support from a speech and language therapist to regain their language skills, and care workers had developed a guide to communication and improving speech together with the speech and language therapist.

The provider was working in line with the Mental Capacity Act (2005) (MCA) but did not always clearly record consent to care. The Act 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. Where it was suspected that people did not have the capacity to make decisions about their daily care, the provider had assessed people's decision making abilities to determine whether they did have capacity. However, in two cases we saw that relatives were signing on behalf of people who had capacity but were physically unable to sign due to their disabilities, and the provider had not explored other ways of documenting people's consent. In one case a person's relative had a lasting power of attorney and had signed their plan. The provider had assessed that the person did not have capacity to consent to their care plan, but had not obtained evidence of the lasting power of attorney.

We recommend the provider take advice from a reputable source on how to evidence people's consent to care when they are physically unable to sign a care plan.

Good

Is the service caring?

Our findings

People and their relatives told us the service was caring. Comments included, "[My relative] is being looked after by a nice agency", "I've got a very nice carer" and "The care workers are really nice and they do a lot for [my relative]".

The provider completed an assessment titled "What's important to me." This included key information on people's priorities for their care, such as being nicely dressed in culturally appropriate clothing and being supported to visit places of worship. There was information on which temples people visited and whether they had a personal temple for home worship. Logs showed the religious support people had such as support to pray when this was identified as a personal need. Plans highlighted people's preferences for the gender of their care workers. Plans contained some information on people's life stories, their place of birth and family background.

People were supported with their communication needs. This was because the service identified people's preferred languages and their preferences for the languages their care workers needed to speak. The provider told us, "The clients that we have speak multiple languages, we have staff that speak those languages. We match people based on language needs and what the client needs". Comments from relatives included, "We understand their language. [My relative] doesn't understand English, they speak her language and it makes a bit difference", "I always demand for a Gujarati speaking lady, you need that communication" and "They have to speak the same language".

Plans also included information on people's non-verbal communication, including how people may communicate by using sounds or objects of reference. One person who had difficulty with speech following a stroke had a bespoke communication plan including photographs and words in several different languages in order to promote their communication.

People told us they had support from consistent care workers. Comments included "It's only one carer" and "It's the same carer every time". This was supported by records of care that showed most people had the same care worker on all visits. Plans highlighted when consistency of care workers was particularly important, for example if a person was living with dementia.

The service provided people with a service user guide, highlighting their principles of care, such as to respect people's rights, privacy and choice. Plans included details on what people could do for themselves such as brushing their teeth independently and what care workers could do in order to promote this. The provider told us, "We ask people would they like to do any aspects of personal care on their own, if they would like the carer to come later." As part of the provider's questionnaire people and their relatives were asked if they felt the service promoted people's independence and showed a high level of satisfaction in this area.

Good

Is the service responsive?

Our findings

Care plans were regularly reviewed in order to make sure that they still met people's needs. Care was planned in several areas, such as personal hygiene, nutritional and hydration, skin integrity and safety. Plans were clear about the tasks that needed to be carried out on each visit and were summarised for easy reference. This included useful information about the order people preferred to have tasks done and how people's needs could vary, such as people who were more unsteady in the mornings. There was information on people's plans on their aims and objectives for their care, such as to develop or regain skills, including guidelines on how to encourage a person to hold a pen and practice writing. Care workers told us that they found these plans to be accurate and useful.

The provider had recently changed their review system from quarterly to monthly. A manager told us, "We have changed the pattern because we felt that we needed to cover every possible area." Plans were reviewed in areas including health and wellbeing, medicines, moving and handling, communication and continence. In most instances there had not been changes from month to month, but areas of concern were highlighted such as changes to people's mobility and whether any further equipment had been recommended such as ceiling hoists. Managers used the review process to check that people's needs remained the same or to assess whether any changes were required.

We reviewed logs relating to people's daily care. These showed that care was delivered consistently on time and in line with people's care plans, but were usually repetitive and did not detail the social interactions or changes in people's moods or conditions which may be useful for reviewing people's care.

The provider had a policy relating to the Accessible Information Standard. The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS. The provider was aware of their responsibilities to provide information in a format relevant to people and had recruited interpreters to help them start to translate information such as care plans and service user books into people's languages.

People told us they had not had cause to make a complaint but were confident they could do so if needed. Comments included, "Everything's OK", "I could get hold of a manager (if needed)" and "We are happy with everything". The provider had a complaints policy which outlined to people and their families how to make a complaint, a timescale for addressing these and external agencies such as the local authority who could address a complaint if this was not resolved. There was a system in place for monitoring and addressing complaints which included recording the resolution and two levels of follow up to the complaint to ensure that people were satisfied. For example, a family had complained that their care worker did not speak their language. Managers had arranged for a care worker who had the right language skills, and had later followed up with the family to ensure that they were satisfied.

Good

Is the service well-led?

Our findings

Managers had systems in place to monitor and improve the quality of care, including regular spot checks and audits.

Managers and co-ordinators carried out monthly telephone monitoring of everyone who used the service. This involved making a telephone call to the person or a relative and asking whether people had any concerns with the care plan, whether their care workers appeared suitably trained and whether they did everything that was required. Feedback from these calls was very positive.

Spot checks took place every three months. These were used to check the skills of care workers, including whether they used appropriate infection control measures, used equipment safely and kept appropriate records of medicines and care provided. Managers also checked whether care workers communicated well, left snacks and drinks for people if required, and whether people were treated with dignity and respect. People were asked whether they were happy with the staff member and whether there were any problems that needed to be addressed.

Managers used the spot check to carry out a three-monthly check of the records kept in people's houses, such as the care plan and medicines records, and to check records of care had been correctly completed and care delivered as planned. A care worker told us "They come and do a spot check, first the timing and to make sure you are using your apron…they give us feedback". A relative told us, "They ask all the questions regarding the carer and is everything OK."

Care workers told us that they felt well supported by their managers. Comments from staff included "It's a very co-operative organisation, the managers are really nice and helpful" and "They are always supportive." Team meetings took place monthly and were well attended by care workers. These were used to discuss policies and expectations of care workers.

Managers carried out regular audits of care files to check that information such as risk assessment and care plans were up to date and that reviews were taking place regularly. There were also audits carried out of care worker files to ensure that the correct information was held and that training certificates were kept up to date. In addition, an audit was carried out across the service and had identified areas for development such as improving the recording of personal care and increasing the frequency of reviews which we saw had taken place. There was a continuing improvement plan for the service where managers had outlined their plans to further develop the service. This included arranging language training for care staff, implementing electronic care monitoring and moving away from paper recording for care plans and medicines records. The provider was in the process of recruiting interpreters in order to improve their written communications.

The provider also carried out a yearly survey of people using the service. This was used to check that people felt safe using the service, that people knew how to make complaints and were involved in their decision making. This showed a high level of satisfaction with the service.