Birmingham Business Associate Ltd

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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?	Requires Improvement

Summary of findings

Overall summary

This announced inspection took place on the 30 and 31 May and 01 June 2018. The provider was given 48 hours' notice that we would be visiting the service. This was because the service provides domiciliary care and support to people living in their own homes and we wanted to make sure staff would be available to talk to us about the service.

Birmingham Business Associate is a domiciliary care agency registered to provider person care to people living in their own homes. The service currently provides care and support to 25 people ranging in age, gender, ethnicity and disability.

There was 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 our last inspection on 08 and 09 May 2017 we found that the provider's recruitment and quality monitoring systems and processes were not always robust and required improvements.
The provider had made improvements to their recruitment processes to ensure they employed suitable staff. Systems had been put in place to audit medication administration records (MARs) and log sheets. However, these audits had not been analysed to identify issues and trends to reduce future reoccurrence.

People were safe because staff had the skills and knowledge to meet their needs. Staff had a good knowledge and understanding of how to spot signs of abuse and where to report concerns to both internally and externally. People had the appropriate risk assessments in place to ensure risks to people were minimised. People were supported to take their medicines as required.

People and their relatives were involved in both initial assessments and reviews of their care. People were supported by kind and caring staff who knew their needs well. People were given choice and control over their care and staff supported them in the least restrictive way, promoting independence as much as possible. People had access to health care professionals when required.

People and their relatives knew how to complain and raise concerns. Complaints had been investigated and dealt with in an open and honest way and people and relatives were happy with the outcome. Feedback was sought from people and relatives via a quality questionnaire and audits were in place. However, the provider had not used the information from feedback, audits, complaints and incidents to identify trends and reduce the chance of reoccurrence.

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 by enough staff to meet people's needs. The provider had robust recruitment processes in place to ensure suitable staff were employed.

People felt safe with staff that supported them. Staff were able to recognise signs of abuse and knew who to report concerns to.

People were supported to take their medicines as prescribed. Risks to people were assessed and monitored.

Is the service effective?

Good

The service was effective.

Staff had the relevant training and knowledge to meet people's needs effectively.

Staff sought consent from people before providing care and support. People were supported with their meals where required.

People had access to relevant healthcare professionals to maintain their health and wellbeing.

Is the service caring?

Good

The service was caring.

People and relatives felt staff were kind and caring and respected people's privacy and dignity.

Staff knew people well including their preferences and preferred way of communicating.

People were supported to maintain their independence.

Is the service responsive?

Good

The service was responsive.

People received care and supported that was personalised.

People and relatives were involved in regular reviews of care and staff were aware of changes in people's needs.

People and relatives knew how to raise complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Although audits and systems had been put in place to monitor the quality of the service, the information from these had not been used effectively to drive improvement.

People and relatives were happy with the service overall. Staff felt supported and found the management team approachable.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place over three days on 30 and 31 May and 01 June 2018. The inspection was announced and the provider was given 48 hours' notice. This was because the service provides personal care and support to people living in their own home and we needed to be sure that the registered manager and staff would be available to meet with us. The first day was spent with the registered manager, care consultant manager and staff at the provider's office and the second and third days were spent making phone calls to people who use the service and their relatives.

The inspection team comprised of one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

When planning our inspection, we looked at the information we held about the service. This included the Provider Information Return (PIR) and the notifications received from the provider about deaths, safeguarding alerts and accidents/incidents which they are required to send us by law. A PIR is information we require providers to send to us annually to give key information about the service, what the service does well and what improvements they intend to make.

As part of the inspection process we spoke with three people who use the service, eight relatives, the registered manager, the care consultant manager and six care staff. We looked at five people's care records to see how their care and support was planned and delivered. We also looked at medicine records, staff recruitment and training files, policies and procedures and the provider's quality monitoring systems.

Good

Is the service safe?

Our findings

At our last inspection in May 2017, we rated the service as 'requires improvement' in this key question. This was because the provider's process for checking past employment references and Disclosure and Barring Service (DBS) history was not robust. DBS checks help providers reduce the risk of employing staff who are potentially unsafe to work with vulnerable people. At this inspection, we found improvements had been made to their recruitment processes. Each staff member's file had a check list at the beginning to ensure all documents were in place prior to staff commencing work and there was a system in place for DBS renewals every three years.

People and relatives we spoke with said they felt safe when supported by the staff. One person we spoke with said, "I feel very much at ease and very safe" and another told us, "I've had no falls and feel very safe and happy with them." A relative we spoke with said "She is very safe with them, if I go out, they look after her and she is happy with them" and another said, "They [staff] use a hoist, they do that ok, no mishaps. If anything is new the other is always ofay. It's never just two new staff."

We found the provider had a safeguarding policy in place and staff demonstrated good knowledge and understanding in relation to abuse. Staff were able to tell us what signs to look for and how to report concerns, both to the registered manager and externally from the organisation when required. One staff member said, "If I noticed bruises on someone, I would call the office to report this and [care consultant manager] would deal with this."

We saw that people had risk assessments in place to reduce individual risks to people. For example, some of the care plans we looked at showed that people were at risk of developing sore skin due to being cared for in bed. There were clear instructions for staff on how to reduce these risks and what to do if they had any concerns. One staff member we spoke with said, "We check skin for pressure sores and if we have any concerns we would call the office, family and the district nurses when needed." Relatives we spoke with confirmed that staff were aware of how to reduce this risk. One relative told us, "They [staff] are very good at avoiding bed sores" and another said, "[Person's name] does have some pressure sores, they are aware and the district nurses are involved as well."

Staff were aware of procedures to prevent infection such as washing their hands before touching food and wearing gloves. Staff told us they had access to personal protective equipment when they needed it. Relatives and people confirmed the correct equipment was worn when staff were providing care. One relative said, "They [staff] use gloves and an apron and tidy up after meals."

There was a process in place to monitor accidents and incidents, including safeguarding referrals. Staff told us, "There is an accident form in everyone's folder in their home, we have to record it on there and inform [care consultant manager]." We saw that safeguarding incidents had been referred to the local authority and investigated by the provider where required. Lessons learnt were shared within team meetings and the provider accepted responsibility where appropriate.

There were enough staff to meet people's needs. Staff told us, "We have enough time and travel time, we always have time to speak to our clients." We were also told that there is always enough staff to cover other staff members shifts when required and annual leave was requested in advance to ensure people's needs were met.

People and relatives told us they had the same staff supporting them and that care call times were usually kept to. One person we spoke with told us, "I have a regular and it's twice a week." A relative we spoke with told us, "They [the service] keep to regular carers, I was scared that [person's name] would not have the same people but they know each other well" and another said, "It's mainly regulars. There are four who work as a team, two each visit. Mainly there are two staff but they are all known to us." One relative explained, "They [staff] are mainly on time but sometimes they run a bit late, not often and not many staff, it's hardly been a problem and they are good, they really show they care" and another said, "[Person's name] would get anxious if they [staff] did not come on time, they realise that."

People and relatives told us that where required staff supported people with their medicines safely. One person we spoke with told us, "They [staff] help me take them all and put them out and give me them" and a relative said, "They [staff] gave [person's name] tablets today and they need to check that they take them." Staff spoken with were able to tell us how they support people to take their medicines and had received training on how to do this safely.

Good

Is the service effective?

Our findings

Staff told us they had regular team meetings and supervision with their manager. One staff member said, "It's very useful, we have it regularly." Records we viewed confirmed supervision had taken place as well as spot checks completed of their practice. These spot checks involved the care consultant manager observing the staff members practice during a care call to identify areas of improvement and ensure staff were meetings people's needs. Staff told us they found these spot checks helpful. One staff member told us, "We have them randomly, they are useful, we get feedback and if there's anything to improve on [care consultant manager] will let us know.

Staff received an induction to prepare them for their role. This consisted of relevant training, shadowing experiences and being made aware of policies and procedures. As part of this process they also completed the Care Certificate. The Care Certificate is an identified set of induction standards to equip staff with the knowledge they need to provide safe and effective care. People and relatives that we spoke with told us they felt that staff were generally well trained. One person we spoke with said, "Yes, they [staff] are well trained" and a relative said, "They [staff] use a hoist and they do it right". Other relatives said "They [staff] are brilliant with bed sore avoidance, not been one" and, "[Care consultant manager] observed them [staff] at first, doing their first shifts, they were being checked." Staff told us they found the induction process useful and that they could request more training if they felt they needed it. The registered manager informed us that they have recently joined with a new training company that offers more training and more frequent refresher training. This will mean that people are supported by staff that have the most current skills and knowledge.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack the capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff demonstrated a good understanding of this legislation. One staff member said, "If someone cannot make decisions for themselves then relatives and professionals have to support them." Staff were also able to give examples of how they gain consent before providing care. One staff member said, "I looked after someone who cannot speak so I will assess their body language and provide reassurance" and another said, "We will ask what they want."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in respect of people in their own homes should be made to the Court of Protection. The care consultant manager told us at the time of inspection they were not providing care and support to anyone who was being deprived of their liberty. We spoke with the registered manager, the care consultant manager and staff about their understanding of DoLS. Although some of the staff members understanding was limited, they were able to tell us what this meant for people.

Most people we spoke with were supported by family for their meals. One person who did receive support with meals told us, "It's a pleasure to have them calling and I can't do without them. They do my dinner, they

make what I want." Staff told us they support some people who require assistance with eating and offer choices before making someone's meal.

People had their needs fully assessed before they started receiving care from the service, they had care plans devised for their individual needs. People and relatives confirmed that they had been involved in this process and that staff members followed the person's care plan. One relative said, "[Care consultant manager] came around and met us and introduced us to some of the carers" and another told us, "They came out and did the care plan with us."

People were supported to maintain their health and wellbeing and had access to other healthcare professionals when required. We saw that were required people had the relevant input from professionals. For example, one person had the district nurses involved in their care due to having sore skin. Staff confirmed that they would call relevant professionals if required, as well as informing family of any changes or concerns. One relative we spoke with told us, "They let me know if he has any signs of anything even a scratch."

Good

Is the service caring?

Our findings

People and relatives we spoke with said staff were kind and caring. One person we spoke with said, "They are lovely. I can chat and have a bit of fun. They are very helpful and very good." One relative we spoke with, told us, "The staff have a lot of natural care and you cannot train for that" and another said, "They are very pleasant people. It's good, I could not fault them." Relatives told us how they felt staff were able to provide reassurance and spoke to people when supporting them. One relative said, "They are gentle and [person's name] is very much at ease with them, not distressed and they know what to do to stop [person's name] feeling anxious. They listen to [person's name] and me."

Staff knew people's needs well including their likes, dislikes and preferences. Staff told us they supported the same people on a regular basis so knew them well and spoke positively about their role and their relationships with people. People and relatives spoken with confirmed this. One person said, "They are lovely. I can chat and have a bit of fun with them." A relative told us, "She [carer] gets on with [persons' name], we've got to know her well, like family" and another said, "The care is good and [person's name] is at ease with them [staff] and trusts them. They've built up a good relationship."

People and relatives we spoke with said dignity and privacy was protected when being cared for by staff. Relatives spoken with told us, "Yes, they are polite and respectful. All are ok" and, "They do her care in privacy. She would tell us if she was unhappy." Another relative explained,
"The care is done with dignity, they protect [person's name] privacy and they chat with [person's name]."
Staff were able to give examples of how they protect people's privacy and dignity whilst providing personal care. One staff member said, "We make sure the curtains are closed, shut the door, cover them up and make sure no one comes in".

Staff told us they support people to be as independent as possible and gave examples of how they do this. One staff member explained, "I get them to do as much as they can for themselves, give them a flannel to wash their face if they can and then support with what they need help with." Care plans also reflected this, they included detail of what a person could do independently and what they required support with. The care consultant manager informed us how promoting independence and enabling people has been discussed with staff during team meetings and supervision, this was reflected in the team meeting minutes.

People were given choice and were involved in decisions about their care. One person told us, "She [carer] makes my breakfast, they make what I want" and a relative said, "They [the service] involved us and they asked us both what we felt and how we would like it [care] and when. They put it all in the plan." We saw that staff received equality and diversity training and care plans detailed people's cultural needs and included information about how to communicate with people in their preferred way. Most relatives told us they felt staff were respectful when in people's homes and speaking with them. One relative said, "She [carer] chats with [person] respectfully". However, there were also some relatives we spoke with that said, 'Sometimes' staff speak in their own language. We saw that the provider was aware of this and was on the agenda at team meetings.

Good

Is the service responsive?

Our findings

The Provider Information Return (PIR) stated that care plans and risk assessments would be reviewed timely to ensure people's needs are still being met. We saw that where reviews had taken place, changes had been made to the risk assessment and the care plan where needed. For example, one person's care plan and risk assessment we looked at showed that there had been a discussion regarding the carers starting to support with medicines, this had been reviewed and changed in the risk assessment and care plan to ensure carers knew their role and the updated information.

People and relatives told us they were involved in the care planning process and that people's needs were reviewed regularly. One person said, "She [care consultant manager] met with me when it was set up and she is coming around again next week and we'll have a chat and a cuppa." A relative we spoke with said, "She [care consultant manager] came out to see us. It was all agreed and at some point, she's done a review" and another said, "They [the service] involved us. They follow up and I speak to [office staff member's name] once a week." We saw from records we looked at that reviews were held every six months or sooner if required due to changes in a person's needs.

Relatives told us that the service was good at contacting them and keeping them up to date about any changes or concerns. One relative said, "They let me know if [person] has any signs of anything, even a scratch, they let me know" and another said, "When [person] came back from respite recently, the carers quickly alerted me that [person] came back with a red mark and it got cleared up". Another relative explained how staff keep them updated via their recording within people's homes, they told us, "They [carers] write notes and I check these, they put down good notes."

The PIR stated that when complaints are received, they are responded to quickly. Most people and relatives we spoke with said they had not had to make a complaint but would feel comfortable doing so. One person said, "Hopefully I'll not need to complain but I would speak up if it was needed though" and another said, "I've had no complaints". A relative we spoke with said, "I only commented about some bits some months ago and they sorted it" and another told us, "We've not had much reason to complain, and we can usually get things sorted." We saw the provider had a complaints policy in place and a log was kept of complaints made. We found complaints had been investigated and responded to in an open, honest and timely way and discussed with staff where appropriate. At the time of inspection, the complaints policy was not available in other formats for people if required. We discussed this with the provider and they advised us of their plans to implement this.

The service was not currently supporting anyone who was receiving end of life care. However, we asked the registered manager, care consultant manager and staff members how they would support someone who required end of life care. They had a good understanding and knowledge of how to support someone. One staff member we spoke with said, "It is about making sure they have a lot of TLC, keeping them comfortable and their care plan would be updated with changes for us to follow."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in May 2017, we rated the service as 'requires improvement' in this key question. This was because the provider's quality assurance processes required some improvement. The provider stated they would make changes to the medication administration records (MARs) and the auditing of these and their quality questionnaire for people and relatives. At this inspection we saw that changes and improvements had been made, however, audits and changes put in place were not being analysed to identify trends and improve the service.

The provider had implemented a monthly MAR and log book audit to highlight any issues with the recording of information. We found that the issues that had been documented on the audit form, were similar for different months. This meant that this information was not being used and analysed to look for trends to reduce the chance of reoccurrence.

We found that the provider had sought peoples and relatives feedback via a quality assurance questionnaire. These had been sent out to people on a regular basis and had been changed to become more user friendly resulting in more responses. Most of these questionnaires had positive feedback about the service and care staff. Some of them had comments about how they thought the service could improve. However, we found that this feedback had not been followed up to address issues raised and consider action required to reduce future reoccurrence. We discussed this with the provider who explained that they had been following up concerns raised. However, as this had not been recorded to monitor trends or document action taken, this could not be corroborated.

One of the comments that was received via the provider's quality questionnaire and via our feedback that we sought as part of the inspection was in relation to care staff sometimes speaking in their own language in people's homes. Although we found that this had been discussed with staff in team meetings and some care staff were taking an English course, this had continued to be raised as an issue that had not been dealt with. Therefore, oversight and monitoring of issues and feedback raised was not robust.

We found the provider had an action plan in place which included areas of improvement highlighted from their previous inspection. Although this was reviewed regularly and updated where required, it did not include other areas of improvement identified from other audits or feedback. The provider acknowledged that there had been a lack of oversight of their processes and audits. Following the inspection, they have put systems in place to analyse this information and take action where required in order to develop and improve the service.

Since the last inspection, the provider had started using an electronic system as a monitoring and allocation tool. The care consultant manager explained that it is used to monitor throughout the day if staff have not logged into a care call, whether they are late and the duration of the call.

People and relatives spoken with told us they were happy with the service and would recommend it to others. One person said, "I would rate them as very good, I would recommend them" and another said, "I've

had no complaints, it's a good service". A relative we spoke with said, "Yes, I would recommend them and have done so" and another one told us, "They rate as between very good and excellent."
Staff told us and records showed that they had regular team meetings to discuss current issues and updates within the service. Staff told us, "We can discuss if we feel a client needs more time and how we are generally working". Staff told us they felt the management team were approachable and 'always' listened. One staff member said, "I have raised concerns that a client does not want to get out of bed so [care consultant manager] has supported me with this and they are now getting up again." Another said, "All the managers are approachable, they always listen and support us."

The provider also had a communication book to ensure all staff, people and relatives were kept up to date with information. This was used in the office for when people, relatives or staff called in to provide information or messages to be passed on. We saw that there were actions documented to show what had been done with that information, for example if it had been passed on to a staff member. Staff and relatives confirmed they were kept up to date on a regular basis about people's needs and changes. A relative told us, "When they ring me its regular and [care consultant manager] is also good at communications" and a staff member said, "They will either call us in the office, ring us, text us and the care plan is updated."

All organisations registered with the Care Quality Commission (CQC) are required to display their rating awarded to the service. The registered manager had ensured this was on display within the service and on their website. The provider had correctly notified us of any significant incidents and events that had taken place. This showed that the provider was aware of their legal responsibilities.

Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We found the provider was working in line with this regulation and had been open in their approach to the inspection.