Blyth Valley Disabled Forum Ltd

Blyth Valley Disabled Forum

Inspection report

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Date of inspection visit:
15 November 2017
16 November 2017

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

The inspection took place on 15 and 16 November 2017 and was announced. This meant we gave the provider 48 hours' notice of our intended visit to ensure someone would be available in the office to meet us.

The service was last inspected by CQC on 12 and 13 August 2015, at which time it was rated good. At this inspection the service remained good.

BVDF is a domiciliary care provider and is registered to provide personal care to people who live in their own homes. The service provides care for people living in Blyth and the surrounding area. There were 250 people using the service at the time of our inspection.

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

People who used the service told us they felt safe, whilst relatives and external professionals raised no concerns about people's safety.

Staff had received appropriate medicines and safeguarding training and demonstrated their knowledge during the inspection.

A lone worker policy was in place and staff felt supported and safe. An out-of-hours phone number was in place for staff.

Environmental and person-specific risks were initially assessed and reviewed regularly.

There were sufficient numbers of staff were on duty to meet the needs of people who used the service. Care visits were planned by a team of co-ordinators and missed calls were extremely rare. Rota planning did not always factor in travel time, meaning there were on occasion small delays experienced by people. We have made a recommendation about rota planning.

Pre-employment checks such as with the Disclosure and Barring Service were in place to ensure staff were suitable to work with potentially vulnerable people.

Training included safeguarding, moving and handling, infection control, health and safety, first aid and dementia awareness. The induction was sufficiently detailed and gave staff a grounding in the provider's policies as well as best practice.

Staff liaised well with external healthcare professionals to support people when their needs or preferences changed.

People who used the service confirmed their consent was sought at all stages of care and that they were involved in the care planning process. Care plans were regularly reviewed and people and their relatives confirmed they were involved. Care documentation however did not always clearly record whether people had consented to the care plan which was in place.

People who used the service, relatives and healthcare professionals told us staff were caring, compassionate and treated people with dignity, respect and sensitivity.

People who used the service and staff confirmed they received generally good levels of continuity and that they were given a rota each week so they knew who would be visiting them.

Staff had received training in the Mental Capacity Act 2005 (MCA) and displayed a good understanding of presuming capacity and communicating well with people to ensure they were able to make their preferences and interests known.

Staff were well supported through regular supervisions, appraisals and ad hoc support by care co-ordinators and the managers of the service.

People who used the service and healthcare professionals told us staff were accommodating to people's changing needs and preferences, for instance late changes to visit times.

People who used the service knew how to complain should the need arise and we saw this information was provided to all people who began using the service. Where a complaint had been made it had been responded to comprehensively.

The registered manager, deputy manager and care co-ordinators were described in positive terms by people who used the service and care staff.

We found auditing and quality assurance systems required improvement, with insufficient managerial oversight of completed care records. Other systems were in place to scrutinise staff practice, such as unannounced spot checks. We have made a recommendation about auditing.

Morale amongst staff was good and the culture was an open one where the management listened to staff and acted on suggestions or concerns.

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 remained good.

Is the service effective?

Good

The service remained good.

Is the service caring?

Good

The service remained good.

Is the service responsive?

Good

The service remained good.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Auditing procedures lacked oversight, particularly regarding completed care records, whilst some documentation regarding people's consent was not accurate.

The registered manager was consistently described as approachable, enthusiastic and accountable by staff and by people who used the service.

The registered manager was supported by a deputy manager and there was a strong team ethic, with staff supported to make suggestions.

Blyth Valley Disabled Forum

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.

The inspection took place on 15 and 16 November 2017 and was announced. This meant we gave the provider 48 hours' notice of our intended visit to ensure someone would be available in the office to meet us.

The inspection team consisted of one adult social care inspector and three experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who used this type of care service. The experts in this case had experience in caring for older people.

Before our inspection we reviewed all the information we held about the service. We spoke with the local authority commissioning and safeguarding teams. We also examined notifications received by the Care Quality Commission and spoke with the local Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make. This document had been completed and we used this information to inform our inspection.

We reviewed questionnaires sent out by CQC to people who used the service, their relatives, staff and external professionals and incorporated this into our inspection planning.

During the inspection we reviewed five people's care files, looked at a range of staff records and policies and procedures. We contacted thirteen people who used the service and eighteen relatives. We also spoke with nine members of staff: the registered manager, the deputy manager, three co-ordinators, one administration officer and three care staff. We also spoke with two external healthcare professionals.

Good

Is the service safe?

Our findings

Feedback from people who used the service and their relatives was consistent in that there were no concerns raised about people's safety. Staff were described as trusted and dependable and people felt safe in their presence. One person said, "They come through the week, once a day, and I know them all. I've had them for years and I have no concerns." One person's relative told us, "I'm absolutely sure she is safe as they are so good with her."

Questionnaires returned to CQC by people who used the service were similar in nature, with none of the 22 respondents raising concern about staff ability to protect them from abuse or harm.

The only area of concern highlighted in the pre-inspection questionnaires was that a small proportion of people who used the service felt staff did not always do all they could to prevent infection control (for instance using hand gels or protective wear). None of the people we spoke with or their relatives had a concern. When we spoke with the registered manager about this they showed us how staff were reminded regularly about the need to adhere to infection control procedures and spots checks were in place to ensure staff adhered to guidance and used personal protective equipment, such as gloves and aprons, appropriately.

These unannounced spot checks of staff were undertaken regularly to ensure they acted professionally, for instance wearing the uniform, arriving on time, wearing protective equipment such as gloves or aprons where appropriate, and cared for people appropriately, for instance demonstrating an understanding of people's medicinal needs and supporting them.

People who used the service and relatives we spoke with confirmed they had never experienced a missed call and we found the provider ensured there were sufficient staff to meet people's needs. People said, "No complaints about them – they're always on time," and, "They generally turn up on time and the office are in touch if not." Some people we spoke with confirmed there could be small delays when other calls ran over or there were unexpected circumstances, but no one we spoke with had concerns about a call being missed. There were three care co-ordinators in place to ensure staff were able to attend planned care visits and, where there were unexpected delays or problems, we saw evidence appropriately trained co-ordinators had attended care visits. This was a small proportion of calls. People were not therefore at risk of neglect through missed calls.

Staff had been trained in the administration of medicines and we found no errors in this regard in the documentation we reviewed. The service had specific supporting documentation in place to help staff, with individual colour coded plans for time-specific medicines and topical medicines. The service did not use body maps in the administration of topical medicines but we saw care plans contained suitably detailed descriptions of whereabouts on a person's body the cream should be applied. The registered manager agreed to review this process to establish if body maps would be more effective for staff and reduce risks of medicines errors.

The medicines policy had not been amended to ensure it was in line with recent guidance from the National Institute for Health and Care Excellence. For instance, there were ambiguous phrases about staff 'prompting' or encouraging people to take medicines, rather than making it clear that staff were responsible for administering medicines. The registered manager was aware of this guidance and demonstrated that they had previously sought external advice on the medicines policy. They were awaiting feedback at the time of inspection. They demonstrated after the inspection that they had received this feedback and were amending their policy.

We saw instances of staff identifying errors made by the prescribing pharmacist when administering prescriptions and that these had been raised promptly by staff in line with their reporting procedures.

In each person's care file we reviewed we saw risks assessments were in place, including environmental risks and risks specific to individuals. For instance, moving and handling risks where a person might require additional staff or specific mobilising techniques. These were detailed and clear to understand. Each risk was categorised as high, medium or low and supported by corresponding actions to reduce the risk, for example ensuring staff referred to advice from an occupational therapist when helping someone mobilise. Each person had a fire safety risk assessment to identify and areas within the home that presented additional risks. Staff were knowledgeable about the range of risks people faced and how they could help prevent harm or abuse from happening.

Records we reviewed were accurate and up to date. Records held in people's homes were returned to the office each month and archived securely.

Staff had a good awareness of the risk of self-neglect, as defined in the Care Act 2014, and had completed a number of 'blitz' care packages, whereby staff would spend a concentrated period of time cleaning a person's home where they had neglected it for some time. The registered manager and deputy manager were able to tell us about the positive impact these one-off calls had had on people's emotional wellbeing. Alongside providing people with this service, we saw staff also raised concerns with appropriate external agencies to ensure people were protected from ongoing significant harm.

All staff received safeguarding training and staff we spoke with demonstrated knowledge and confidence in what they should do if they had concerns about people's wellbeing. The provider had in place suitable safeguarding and whistleblowing policies. Whistleblowing means raising concerns about an employer externally.

All staff files we reviewed contained evidence of pre-employment checks including enhanced Disclosure and Barring Service (DBS) checks. The DBS restrict people from working with vulnerable groups where they may present a risk and also provide employers with criminal history information. The registered manager had also asked for at least two references and ensured proof of identity was provided by prospective employees prior to employment. This meant that the registered manager ensured the risks of employing unsuitable people were reduced.

Good

Is the service effective?

Our findings

In questionnaires returned to CQC, 23% of respondents stated they felt staff did not always stay the full length of time. When we spoke with people who used the service and their relatives, a significant majority told us that staff stayed for the agreed duration of care visits. People we spoke with stated, for example, "Oh yes, they stay for the allotted time," whilst relatives told us, "They never rush him and stay for the duration," and, "They usually stay the full amount of time and, if they don't, they make up for it." There was a strong consensus of opinion from the people and relatives we spoke with that carers were generally on time and stayed for the duration of calls, and that when this did not happen it was rare and, ordinarily, people were given advance notice of this by office staff.

We reviewed the care visit planning procedures, which were undertaken by three co-ordinator staff who worked well as a team. They ensured care visits were planned a week in advance so that people who used the service could be sent a list of which carers would be visiting them and when. People we spoke with confirmed they received this and that late changes were minimal. Care staff had company mobile telephones and both they and office staff confirmed communications between staff on care visits and in the office was strong. This meant, where there were last minute changes, they were well communicated.

The planning of the rota did not always factor in travel time between care visits. Whilst at times this presented no additional pressures on staff, for instance where the care calls were in the same street, there were occasions where this was not the case. For instance, one care call finished at 4pm in one area of Blyth but the next care call was due to start at 4pm at the other end of Blyth. We saw other instances of this. One staff member told us, "Sometimes it's a bit tight getting between calls – usually it's okay," whilst another said, "If I could change one thing it'd be travel time."

The National Institute for Health and Care Excellence (NICE) guidance, 'Home care: delivering personal care and practical support to older people living in their own homes (September 2015)' states providers should, "Ensure service contracts allow home care workers enough time to provide a good quality service, including having enough time to talk to the person and their carer, and to have sufficient travel time between appointments." We found, whilst this happened in the majority of cases, the provider could do more to ensure staff always had adequate time to get from one appointment to another. We recommend that the service considers current guidance regarding planning home care visits and reviews current practices on this basis.

People who used the service and relatives felt care staff were appropriately trained and skilled to care for them. One person said, "They are all well trained and know what they're doing when they come," whilst another said, "They definitely understand my needs and complete all the tasks properly." One relative told us, "Oh yes, the regular ones know what to do. They are good with the catheter." Other relatives gave examples of moving and handling proficiency demonstrated by staff and we saw this aspect of staff training was delivered by an external training provider.

The provider had in place an induction process which included all the training they considered mandatory.

This included safeguarding, fire safety, health and safety, food hygiene, first aid, dementia awareness, infection control, moving and handling and mental capacity awareness. Staff told us, for example, "There's loads of training and they check up on this with supervisions and spot checks." We found the provider's induction process to be in line with that experienced by staff and that staff were well supported to learn the skills required. Staff also confirmed they were well supported by senior colleagues to progress their vocational qualifications, such as an NVQ in social care. The deputy manager had included excerpts from key policies in the induction documentation to ensure staff, who signed to confirm they were aware of the service's policies, had sight of these. The induction process provided a suitable introduction to the provider's policies as well as the skills needed to perform the role. We saw the provider has also recently installed a resource centre in the building with a number of computers, meaning staff could complete distance learning courses when they visited. This had just been completed at the time of the inspection so the impact was as yet unclear but staff we spoke with were optimistic about it.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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. We checked whether the service was working within the principles of the MCA. Staff had received training in the MCA and displayed a good understanding of presuming capacity and communicating well with people to ensure they were able to make their preferences and interests known.

Staff gave examples of how they included people in decision making, for example people living with dementia who may need more support and encouragement to be involved in a decision. One staff member told us, "It's just a slightly different conversation. You can't always have an open question. If we're deciding what to have for breakfast I'll get out the different cereals or breads so they can see a range of options. It's better that way."

Other people who used the service confirmed they were supported to make decisions about meals based on their preferences. One person told us, "They are very good at encouraging me to be independent," whilst another said, "Meals are fine, yes, they are a whizz." One relative told us, "The carers encourage him to eat healthily but respect his choices" and another said, "She grazes so the girls tend to make her snacks rather than big meals." This meant people and their relatives had confidence in the ability of staff to support people to choose a diet of their preference.

With regard to how people's involvement in care decisions was recorded, this required improvement. There was a lack of clarity in care documentation regarding whether people had consented to the care they were receiving. For example, some care documents, which had a signature section for the person receiving the service, had been signed by a member of staff with a note stating, "[Person] unable to sign." It was not clear whether they had wanted to sign but were unable, or had merely not been asked. Similarly, other documents requiring signature by people who used the service had in the signature section, "Discussed with [person]." Again, it was unclear what this meant in terms of whether the person had given consent to the care plan set out. When we spoke with a significant number of people who used the service and their relatives, they all confirmed their consent had been sought for the care plan and individual decisions. This meant, whilst staff had regard to the need for consent, this was not always accurately documented. The registered manager agreed to review the MCA code of practice and ensure their documentation regarding consent was improved.

Good

Is the service caring?

Our findings

People who used the service and their relatives provided consistently positive feedback about how staff treated them in a respectful, dignified and caring manner, and that they valued the relationships they had formed with staff. People told us, "Oh aye, we have some banter. They are all pleasant and there are no grumbly ones amongst them." Another said, "They are very kind and compassionate – we get on really well," and another, "The girls are lovely, great caring lasses and we have a good laugh." This balance of people feeling cared for but also able to express themselves comfortably was a theme in the feedback we received.

We saw a range of documentary evidence such as thank-you cards which detailed examples of compassion and dedication to people. One relative for instance wrote, "It was hard but without Blyth Valley Disabled Forum I would not have been able to cope…so many lovely, kind, professional carers."

The service's annual surveys' of customer satisfaction demonstrated people were for the most part satisfied with the support they received. Typical comments included, "There is always a smile when they come in and they are very helpful," and, "They make me feel comfortable even though I suffer from anxiety." Surveys returned to CQC contained similarly positive feedback, with a significant majority of respondents confirming they were introduced to staff before they began providing care. People who used the service and relatives confirmed they were introduced to carers prior to care visits beginning. This meant people had confidence in who was going to be visiting them and did not suffer unnecessary anxiety in this regard. The importance of maintaining a continuity of care was highlighted as an area of best practice for domiciliary care providers in guidance issued by the National Institute for Health and Care Excellence (NICE) in their publication, 'Home care: delivering personal care and practical support to older people living in their own homes' (September 2015).

People's dignity was upheld through staff who were respectful of their individualities and need for personalised approaches to communication. Relatives and people who used the service told us how staff spoke slowly with people where needed, or gave short, closed questions to people who could not take in complex information. One relative told us, "[Person] is not easy to understand but they take their time and are fine." People told us staff used discretion when providing help with personal care, for example, "They always respect your privacy and they always ask if they can go into the bathroom even if they've done it a million times before."

Care plans were written in a person-centred way and provided staff with detailed background information, including about people's religious beliefs. For instance, one person's religion was noted in their care file, along with some key facts about what this meant for the person who used the service, so that staff could be better and more sensitively informed.

People confirmed their consent was sought in day-to-day care interactions and that they were involved in their care planning. One person told us, "They come and check on me and look at the plan – I do all that too," whilst another said, "They come from the office to see me and they always keep me involved." Surveys returned to CQC indicated that all the vast majority of people who used the service felt involved in decision-

making about their care and support needs.

We saw sensitive personal information was stored securely and archived promptly. This meant people's sensitive information was treated confidentially.

Good

Is the service responsive?

Our findings

People's changing needs and preferences were listened to and acted on by care staff and office staff. People who used the service gave examples of where they had preferred or needed different times of visits, care staff or the type of care visit, and confirmed staff were amenable to this. One person said, "I'd had a problem with a particular carer and they fixed that immediately. The manager was sympathetic and said to me, 'It's really important you feel comfortable with your carers.'" Another said, "You only have to ring them" and was complimentary about the accommodating nature of both care staff and office staff.

Care records were sufficiently detailed for staff to understand people's life history, preferences, likes and dislikes. Each care plan had a 'Your Initial Care and Support Plan', which was more practical in terms of what task the person needed support with. There was also a 'The reasons why you need care and support', which gave more information about how that person required particular support by staff (for instance, with detailed information regarding mobility, medicinal needs and staffing levels required). There was also a 'Your life' section and 'What you want to achieve', which contained the kind of information useful for staff when understanding a person's character and personality, prior to meeting them, for instance, how independent they wanted to be, what the important things in life for them were.

People's needs were reviewed regularly. We also saw staff regularly assessed a range of input, such as advice from occupational therapist and nurses, to ensure people's care plans were accurate and responsive to the changing needs of people. This meant the provider ensured people's needs were reviewed to ensure they were receiving the right amount and type of care.

Care co-ordinator staff demonstrated a knowledge of staff backgrounds and people who used the service, meaning they had a good idea of which carers may be best suited to support people. Whilst this was not as formal as a 'matching' service, we found good examples of people sharing a rapport with their carers, for example a keen interest in football or a television show. Given the service often received requests to provide care and support packages at late notice, the fact they had regard to people's personalities and how they may or may not bond with staff was an area of strength, underpinned by a good continuity of staff.

One person who used the service told us, "Quite a while ago I did feel I needed to complain about one person – they sorted it out quickly though" and a relative said, "I did complain and it was resolved straight away so no problems." We saw the service had a clear and accessible complaints policy in place and a log to chart the type of complaints received and whether any trends were developing. A recent complaint we reviewed had been dealt with comprehensively by the registered manager. Surveys returned to CQC indicated that a significant majority (91%) of people who used the service knew how to make a complaint.

One external professional we spoke with told us how proactive staff had been in establishing a person's changing preferences and acting on those changes. They said, "The care organiser and carers were instrumental in arranging and working in partnership with myself and finance department in arranging a holiday. The care staff worked with the clients to keep them informed of the travel plans and supported them to ensure they had everything they needed for the holiday. Clients were very happy with the holiday[s]

and more importantly the support they received from care staff."

Nobody who used the service at the time of inspection was receiving end of life care but this was an area where the provider had been proactive, identifying which staff wanted to increase their skills and knowledge in this area and arranging additional training. We reviewed an archived care record and it demonstrated staff had worked alongside external nursing professionals to ensure people could be as comfortable as possible as they approached the end of their lives. We saw appropriate plans in the care files we reviewed, should people's needs change and they require end of life care. Where people wanted to make advance decisions about the type of treatment they were or were not comfortable receiving, we saw this had been documented in their care file and staff were aware of these preferences.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection, the service had a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service. The registered manager had relevant qualifications in adult social care and was supported by a deputy manager who had worked in a number of roles in the care sector previously and displayed a good working knowledge of people's needs.

All staff we spoke with, including office staff and care staff, expressed confidence in their management and confirmed they were approachable and accountable. One said, "I love my job and I'm well supported. I worked somewhere else but came back. There's always someone on call so you know you're never really alone." Another said, "They are open to suggestions – there's a suggestions box in the tea room – and they listen to you if you think a call needs more time or if someone needs different help. You don't feel isolated."

All staff we spoke with confirmed they felt part of a team and that they saw their peers regularly at team meetings. The registered manager acknowledged these meetings had occurred less frequently than previously and that they intended to address this. Staff also confirmed they received annual appraisals and regular supervisions where they could raise any concerns they had.

In staff questionnaires returned to CQC, all respondents agreed they felt confident they could raise any questions regarding practice with their manager, that advice was available, and that their views were taken seriously.

People who used the service and their relatives raised no concerns about the leadership of the service and were positive in their feedback. People who used the service we spoke with were in agreement, stating, "The office is very helpful but I don't have to ring them much," "I think they are well organised and I haven't had any problems with them," and, "You only have to ring them if you need anything – it's great."

Questionnaires returned to CQC indicated that 96% of respondents knew who to contact at the care agency should they need to, whilst a similar proportion of respondents felt the information they received from the service was clear and accessible.

External professionals we spoke with told us they found individual staff to be helpful and that the service was well-run. One told us, "I have always found them to be a caring, supportive company whose staff provide an excellent service to my clients." This meant all people we spoke with during the inspection felt the company was effectively run.

Quality assurance and auditing processes were not always coherent or well managed. We found there were some good overarching checks completed annually by the deputy manager to ensure the service had appropriate policies and systems in place. What was lacking however was regular managerial oversight of individual care records and information for the purposes of quality assurance. We asked the registered manager what processes were in place to check a sample of people's care records when they were returned to the offices on a monthly basis for archiving. The registered manager acknowledged there was no scrutiny

of this documentation prior to it being archived. This meant one of the main areas for identifying any patterns of concern in paperwork, or areas of good practice, was not being acted on. Effective auditing could, for example, have identified the inconsistent approach to documenting how people consented to care. The registered manager and deputy manager agreed this was an oversight and that they would review their auditing procedures. We recommend that the service seeks guidance and advice regarding its quality assurance procedures and ensures they are improved.

We saw some regular checks of practice were in place, such as unannounced spot checks of care visits, which would look at staff timeliness, professionalism, interactions with people, knowledge and medicines administration competence. This meant, whilst the auditing of completed care records required improvement, the registered manager had ensured there was a level of scrutiny of staff practices to ensure people received safe and effective care.

The registered manager and deputy manager had attended an external event recently regarding changes to practices regarding medicines administration. They had proactively engaged with external professionals regarding how best to update their policies, which demonstrated they kept under review the relevance and effectiveness of their policies when considered against new national guidance or best practice.

The registered manager and deputy manager engaged with people who used the service through intermittent spot checks, care reviews and annual surveys, which were due to be sent out at the time of inspection. We reviewed the previous survey results and found they provided consistently positive feedback about the service. The deputy manager had analysed the information. The service also previously arranged a forum whereby people who used the service, family members and staff could meet to discuss any common queries or concerns. The registered manager confirmed this had not taken place for a number of months due to a lack of interest, but that they would consider reinstating it.

We found the culture to be one where staff were well supported and could raise concerns openly, whilst people's needs were met by staff who were passionate about providing effective care to people. Staff worked well with each other and with external professionals and agencies.