

Britannia Homecare Ltd

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Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Britannia Homecare Limited is a domiciliary care agency that provides personal care to people in their own homes living in and around East Surrey. People who receive a service include those living with physical frailty due to the progression of age. The agency also provides services to people living with dementia and people with mental health needs. At the time of the inspection, the agency was providing a service to 202 people of which 117 were receiving personal care as part of their package of care.

There had been no registered manager in post since 29 January 2018. 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. Two managers had submitted applications to the CQC to become joint registered managers.

We last carried out an inspection of this agency on 7 June 2016 when the service was rated as requires improvement in the safe domain. We recommended that the registered provider reviewed systems and structures to improve visit call times. We also recommended that the registered provider reviewed medicines procedures to ensure accurate records were maintained. We found similar shortfalls at this inspection.

During this inspection we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to medicines management. We also made five recommendations to the registered provider in relation to staff deployment, recruitment processes, staff training, risks related to people's dietary needs and good record keeping. You can see what action we told the provider to take at the back of the full version of this report.

There were insufficient numbers of staff to care for people and as such management decided to hand back packages of care to the local authority in order to ensure they could provide suitable care to people. However, deployment of staff needed to be improved as we found people had mixed views about the timings of their visits and call times allocated by the agency did not always allow for sufficient travelling time between visits.

Medicines were not always managed safely. There were unexplained gaps in medicine administration records and body maps were not being used to record the use of creams and pain patches. Accidents and incidents were recorded and risk to people had been identified. .

Recording on food and fluid charts was lacking which meant people may be at risk of malnutrition or dehydration.

Staff did not always receive training at regular intervals to ensure that they received the most up to date training although management had an action plan in place to address this.

People were protected against the risk of infection. Staff had infection control training and had access to the necessary equipment. People were protected from the risk of abuse because appropriate safeguarding procedures were in place.

Management had started to address shortfalls within the agency. They had introduced an audit system which had identified shortfalls and were not working to an action plan to address these.

People's care plans did not always include a sufficient amount of information to ensure that staff knew exactly what care they should be providing. People's end of life wishes were not recorded to help staff understand people's preferences. We did find however that new-style care plans were being introduced to make information clearer.

People's choices were considered and they were involved in making decisions about their care. People told us they were encouraged to be independent and that they were cared for by staff who were kind and caring and showed them respect and dignity. People were encouraged to feed back their view about the service they received. People could telephone the office in and out of hours if they needed to speak to someone about the care they received. They also told us they would know how to make a complaint.

People were supported at mealtimes and staff ensured that people had enough food in their homes. Staff responded to the needs of people by contacting health and social care professionals where necessary.

There was a clear vision with the new management structure. The team recognised the shortfalls in the service and were taking steps to make improvements. Staff told us that there was a positive working culture. They also told us they felt supported and that managers were available and approachable. Staff felt that they could contribute their ideas on how to improve the service. Staff said management gave constructive feedback at supervision. Communication was good between staff and management and between management and people who used the service. Management encouraged working with outside agencies and were working with the Surrey quality assurance team with the aim of driving improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe.

Robust medicines management practices were not in place.

Staff deployment was such that people did not always receive care calls when they were expecting them and people told us staff did not always stay the full time.

Risks to people had been identified.

Staff recruitment practices were not as robust as they should be.

People told us they felt safe and staff knew how to identify and report abuse.

People were protected from infection because staff followed the correct infection control procedures.

Requires Improvement ●

Is the service effective?

The service was not effective.

People's food and fluid charts were not always filled in and care plans had not always been updated to include dietary requirements.

Although staff received an induction, ongoing training was not always carried out at regular intervals to ensure best practice.

People's needs had been assessed before they commenced with the agency.

Staff followed the principals of the Mental Capacity Act 2005 in relation to people's care.

People were supported to have access to healthcare professionals.

Requires Improvement ●

Is the service caring?

The service was caring

Good ●

People told us they received care from staff who were kind and caring and treated them with respect and dignity.

People could make decisions about their care and were involved in their care plans.

People were encouraged to be as independent as possible.

Is the service responsive?

The service was not consistently responsive

People care plans were not sufficient contemporaneous in that their end of life wishes were not recorded and information that was important to staff was not recorded.

People knew how to make a complaint.

Requires Improvement ●

Is the service well-led?

The service was not consistently well-led.

Although new management had started to address issues within the agency there was further work to do to ensure people received good quality care.

Quality assurance audits had been carried out and had identified shortfalls. An action plan was in place to address these.

Management was approachable and supportive. Staff were proud to work for the agency. There was a positive culture and a clear vision.

Staff and people's views were considered through regular surveys.

The service actively sought to engage with other relevant agencies for the benefit of people.

Requires Improvement ●

Britannia Homecare Limited

Detailed findings

Background to this inspection

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

This inspection took place on 2 July 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to assist with our inspection. The inspection was carried out by three inspectors.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what does well and what improvements they plan to make. We reviewed information we held about the service including previous inspection reports, information from statutory notifications sent to us by the provider about incidents and events that occurred at the agency. A notification is information about important events which the provider is required to tell us by law. We also reviewed information sent to us by the local authority in their quality assurance monitoring visit report which they carried out on 18 May 2018.

During the inspection, we spoke to seven people receiving care and support and five relatives on the telephone. We also spoke with two managers, two directors and eight care workers. We looked at six recruitment files, ten care plans, audits, staff training and support records, policies and procedures, minutes of meetings and accident and incident reports.

Following the inspection, we contacted two healthcare professionals for their views on Britannia Homecare Limited.

Is the service safe?

Our findings

People told us that they felt safe. One person told us, "They always shut the door and make sure I'm safe." A relative said, "They [the carers] always make sure he uses his stick and wears his care-line (pendant alarm)."

However, we found that people's medicines were not always managed safely and in line with best practice. We reviewed six medicine administration records (MARs) and found gaps in recording in all of them. One person's MAR chart had a gap for a medicine on 29 April. Also on 4 and 6 May their MAR had a line through on those days with no explanation as to what this meant. The same person had been in hospital for around a month from the end of March 2018, but the correct code was not entered on the MAR sheet for this, instead it was left blank. Another person's MAR chart showed gaps for four different medicines on 1 March and 18 March 2018 at 10:00 and for one medicine on the 15 April 2018. This showed that either the person had not received the medicines as prescribed or staff had failed to record that they had been given and taken. We found that the medicines audit carried out by management had not picked up on any of these errors.

Management told us that they did not use body maps for the safe application of patches and creams. One person's care plan noted, "Homecare workers apply pain patches." There were no body maps in the care plan or medicines folder. This meant if a pain patch fell off staff would not know which side to apply a new one or how to apply the patches to prevent skin irritation.

The failure of the provider to follow safe medicines practices was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were cared for by a sufficient number of staff, however staff deployment needed to be reviewed. Staffing levels were maintained after the provider handed back some packages of care to the local authority because they were unable to fulfil all people's visits. The manager told us, "We are being very selective in terms of taking on new packages of care. We will only take them on if we can be really sure we have staff available." They added, "We've had nine to ten new staff starters and are on an on-going recruitment drive." However, we received mixed comments from people in relation to their visits and whether staff arrived on time or stayed the full time expected of them. One person told us, "The last few weeks they've been better. They sometimes call in advance if [they are] going to be late. They're sometimes late because the person before has been unwell." Another person told us, "They are mostly on time." We asked another person if staff stayed the full length of time they were expecting them to and they told us, "No, they do go early. I put that down to lack of staff which is a shame. But they do make sure that everything is done first." Despite people telling us they had raised this as an issue with the agency, it still had still not been fully addressed

Staff and professionals also gave differing views regarding whether staff stayed the correct time with people. A staff member said, "I give the right amount of time for my clients. I make time for my clients." Another staff member told us, "You don't get travelling time, but they don't overlap your calls, so you have enough time to get there [to the next person]." However, a healthcare professional told us, "I don't feel that they [the care staff] are spending the time they are supposed to with service users." We found that travelling time had not been allocated between all calls which meant staff may end up running late. One member of staff said,

"There's not always travelling time built in to the rotas. I start earlier if I need to make sure that I've got time throughout the day."

We recommend that the registered provider ensures that there are sufficient number of staff deployed in order to make sure that they can meet people's expected care needs.

Staff underwent a recruitment process before they started working at the agency. However, we found that not all of the information held about a prospective staff member followed Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because some staff files were missing information regarding employment dates at staff's previous jobs as well as reasons for leaving. Others were missing health declarations. We did note however that each prospective staff member had undergone a Disclosure and Barring Service check.

We recommend that the registered provider ensures that safe recruitment processes are followed to help ensure that staff employed by the agency are suitable to work in this type of care setting.

There was a business continuity plan in place where rotas were planned for the following week. People told us that it was easy to speak to managers by phoning them. There also told us there was an out of hours phone number for people to call. We asked one person about this and they said, "Yes I've got the number in the pack here."

People were protected from the risk of abuse because staff had had the relevant safeguarding training and were able to tell us about their awareness of safeguarding processes and procedures. A member of staff said that if they became aware of a person being abused, "I would tell my supervisor." Where there had been safeguarding concerns the provider had notified the local authority and had taken appropriate actions in response to these. There was a whistleblowing policy in place and management encouraged staff to speak up if they saw or heard anything relating to poor care. A staff member told us, "Most people here are aware that they must whistle blow and tell the office." There were risk assessments in place to keep people safe and staff knew how to care for people taking the risks into account.

People were protected from the risk of cross contamination because the provider made sure that staff had access to personal protective equipment (PPE). There was infection control training delivered to staff. The infection control policy was implemented and monitored effectively. A person told us, "They always wear gloves and aprons, and they always keep things clean."

Is the service effective?

Our findings

People were supported by staff who received an effective five-day training course (induction) when they started to work at the agency. This included training on infection control, personal care, pressure sore awareness, moving and handling, safeguarding adults, health and safety and first aid. After this they shadowed senior staff. Staff told us that they thought the training was good. One of them said, "The training is very good, as is the support. The work ethic is good and the training of new staff is second to none."

However, regular review of staff training was not carried out. The first aid awareness training was scheduled to be completed every year but we noted that 37 staff out of 71 were overdue going on this course. In 15 of these cases, it was overdue by two years. Again, the manual handling training course needed to be done every year but 37 staff were overdue, 10 of which by more than one year. Medication training also needed to be completed yearly but we saw that 23 staff had not completed this in the last year and 14 of these staff should have done this training in 2016 and 2017. An audit had been carried out by management which had already identified the shortfalls in training. They had produced an action plan following this audit which included dates of planned training.

We recommend that the registered provider ensures that any outstanding mandatory staff training is completed within the recommended time frames.

Staff said they felt supported. We read that regular one to one supervisions were carried out. One staff member said, "I get regular support and supervision. I always like to give over my points. They're quite good at listening."

People's needs were assessed before they started to use the agency and a care plan was developed as a result of the assessment. People received a call from the office one week after commencing with the agency to review their care needs to help ensure they were current. There was a further call again after four weeks. All care plans were reviewed yearly and these involved the person receiving the care.

However, we found that recording of people's dietary requirements and the monitoring of their nutrition and hydration was not always in place for those people identified as at risk. One person's care plan showed that their nutrition and hydration should be monitored closely, due to weight loss, using food and fluid charts and observations of eating and drinking. However, this person's care plan did not include food and fluid charts. Another person had been identified by the continuing healthcare team (CHT) as requiring pureed food. Although this person lived with their husband, their nutritional care plan did not make it clear they should be on a pureed diet.

We recommend that the registered provider ensures food and fluid charts are completed where appropriate and that dietary requirements are included in care plans in order to ensure people are receiving effective care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the agency was working within the principles of the MCA and found that they were. The provider had the appropriate policy in place and staff had received training on the MCA. We noted in one person's care plan that the person could, "Understand simple commands." The person had signed their care plan previously so appeared to have capacity to agree to their care. In another person's care plan, we saw that the staff had documented that the person was, "Able to communicate needs." We asked one person if staff asked for their consent before doing something and they replied, "They ask for consent before doing anything." This showed that staff understood and demonstrated the clear principles of the MCA.

People were fully supported to access the healthcare they needed. For example, one care plan identified continual communication with other agencies involved in a person's care. In the daily notes it was recorded that they had been refusing to eat and seemed in a low mood. We spoke with management about this who were able to evidence they had contacted the GP and had spoken to their next of kin. We saw another example where a care worker discovered a 'large open wound the size of a small finger nail which wasn't bleeding' on a person. They informed the office straight away and called the district nurses so that they could follow up and treat the person.

Is the service caring?

Our findings

All of the people we spoke with were positive about the care they received. One person said, "They're all very good." Another said, "They're all very friendly, if I want anything done they do it. It's comforting to know they're coming." People told us that the staff were caring. One person said, "Yes, they're always polite." Another person said, "They're very friendly, they chatter on and keep me up to date on the gossip," and a relative said, "They're [staff] genuinely interested in mum."

People were supported in a compassionate way and were given emotional support when needed. One person told us, "They're kind. I (can) cry a lot but they make sure that I am okay." Another person told us, "They treat me with kindness." Staff told us that they could spend extra time with people when needed. One said, "I was able to spend another hour with a person because they needed it, so I called the office."

People told us that someone came to meet them when they first started using the agency to discuss their needs and that they could make decisions about their care. One care plan stated, 'I would like my carer to give me a choice of what I would like for breakfast' and another stated that the person wanted female carers only. We saw evidence that their wishes had been respected. A member of staff told us, "Everyone is entitled to make their own choices."

People were encouraged to make their own decisions about their care. One person told us that their relative could do this when the care package was set up. Another relative told us that they were involved in their family member's care planning and had someone from the agency come to see them in hospital a few days before the care package started. One person told us, "Yes, I've met the owner actually. She comes once a year to make sure I'm happy." In addition to this spot check calls took place. One relative said, "Everything asked for is being done, quite happy."

People said they were treated with dignity and respect. We spoke to a family member to ask if staff treated their relative with dignity and respect and they told us, "All of them are caring. The doors and blinds are always closed if they're dressing him, and they always make sure he is dried before dressing him." When asked if staff treated their homes and belongings with respect and one person said, "Definitely." Another person told us, "They always keep my house and belongings tidy." A third person commented, "They treat my home with respect. If there's anything I want doing, they do it."

When asked, if staff encouraged people to be independent and do things for themselves everyone said that they did. We saw a care plan which stated, "They can independently wash their upper body, armpits and face but needs help with other areas." This showed us that staff were prompting people to stay independent where possible. A person told us, "They know me now and know I try to be independent anyway."

Is the service responsive?

Our findings

People's care plans were being reviewed to make them more person-centred. The new style care plan being introduced by management included a, 'what is important to me' page which had information on people would like to achieve. However, at present we found care plans did not always include all of the information necessary in order to ensure that people would receive responsive care. One person had a mental health condition and although there was guidance for staff on how they needed to support the person with this there was no background information on the person's health needs and no personal information or likes or dislikes recorded in their care plan. This meant staff may not have the information they needed to recognise triggers or be able to use tactics in order to support this person when their mental health was not good.

People may not always get care responsive to their needs. The provider had difficulty providing a service to people at the times they wanted. For instance, we saw in one person's social care review on 19 March 2018 that their morning call should be at 9:00 but records indicated that staff arrived frequently around 10:20. In addition, because this person was anxious of the dark they liked to go to bed at 18:00 but at times evening calls were around 21:00.

People's wishes at the end of their lives were not recorded in their care plans. One person's care plan did record where the local hospice was involved in their care, but we did not see a specific end of life care plan for them in order to help ensure staff provided care in line with this person's preferences. However, staff did receive end of life care and dignity in care training every three years.

We recommend that the registered provider ensures that records held in relation to people are contemporaneous in order that people receive person-centred care.

People told us that they knew how to make a complaint. One person said, "Yes, there is a procedure package here with it in, but I've never needed to complain." Another person told us that they had, "Never needed to make a complaint other than cancel a couple of calls due to [staff] being late but they knew to call the office to tell them and they were very polite about the situation."

Is the service well-led?

Our findings

The agency was not meeting the requirements of registration as there had not been a registered manager in post since 29 January 2018. However, two senior staff had recently applied to CQC to become registered managers and we saw a memo introducing them to staff.

Management were starting to take more responsibility for audits. They showed us that falls, accidents and incidents, safeguarding and health and safety audits were to be started on a regular basis. There was also a plan to carry out a three-monthly spot check on medicines competencies on staff. Some audits had started but these had yet to make a real impact on the agency and demonstrate embedded practices.

People were able to express their views in relation to the service they received. In 2017 the agency sent out 359 questionnaires to people and received 138 responses. The results were positive apart from whether staff arrived on time and stayed for their allocated amount of time. We asked management how they planned to address this. 'They told us that staff used an app on their mobile telephones to check in and out when arriving at people's homes. They said the system was used to check care staff completed calls in a timely manner and it was checked daily by care coordinators at the office.

Management had identified shortfall in people's care plans in that they were not person-centred and they had started work to review all care plans as a result. A member of staff told us, "At the moment we're in a transition where the new manager is slotting things in to place. [Staff] are being told about medicines – you always make sure you sign the MAR sheet if you give someone medication as you need an audit trail. All the little things are started to be nailed down. The management is really good."

Management encouraging openness and communication between staff. A staff member said, "We're now encouraged to speak to other carers and ask for second opinions or to make them aware of a situation with that person for when they go in to them." This greater cooperation and collaboration among staff would benefit the people they care for.

A staff satisfaction survey was carried out in May 2018. The survey results showed greater than 90% positive feedback in all areas including how well supported staff felt. Comments included, 'listen to me more, give notice on rota changes, sometimes feel overworked, not so many calls'. The actions by management in response to this were to, 'book supervisions for staff so staff feel supported, further staff meetings to be arranged, develop systems of care packages by ensuring staff have relevant information prior to going in the first time'. We saw that management had started to instigate many of these actions.

Staff we spoke with were positive about the agency. A staff member told us, "The general culture is to do a good job." They also told us that they thought the vision of the agency was to, "Provide independent support for local people." Another member of staff said, "This is the best company I have ever worked for. They care and they show they care."

Management supported staff and cared for their wellbeing. One staff member told us, "They bent over

backwards to help me with family issues. I received a courtesy call from the manager every other day to check I was okay and see if I needed anything." A person told us, "The coordinators are excellent – they always pick up the phone."

There were regular team meetings and we noticed that the most recent one was held on five separate days to give all staff the opportunity to attend. Minutes showed that the agenda covered MARs, safeguarding reminders and reminder to staff about ensuring people had fluids in the hot weather. One member of staff we spoke to said, "They listen to us staff and try new ideas." This showed that management valued the views of staff while encouraging them to deliver a good quality service.

The provider worked in partnership with other agencies. For example, they had contacted Parkinson's UK for them to do a talk for staff. To further aid their learning, they had also arranged for staff to spend some time at a local day centre to observe how to support people living with dementia. The agency had been working with the local authority quality assurance manager and the local commissioners to address shortfalls identified in the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured people received safe care in line with medicines management.