Learning and Development Bureau 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service: Learning & Development Bureau Ltd is a domiciliary care agency that was providing personal care to three people aged 65 and over at the time of the inspection. The service is also known as 'Carer House'.

People's experience of using this service:
Prior to the inspection there was a significant lack of records at the service in that risk assessments had not been completed and care plans lacked details. This meant that people had not always experienced safe care. Some of these issues were addressed during or immediately after the inspection but there were still areas that needed to be improved.

The support people received with their medicines was not always safe. For example, there was a lack of information on what medicines were for and what to do if a person did not take their medicines.

There was enough staff to meet people's needs. There was some continuity of staffing where people had regular carers and these carers knew people well. However, continuity of care was not always consistent. Some staff were late to calls and some calls were missed.

Staff did not always provide support in a respectful way although when issues were raised about this they were addressed by the provider, but there were still some ongoing concerns.

Staff had received the training they needed however, there were concerns about how staff practiced manual handling on two occasions.

There was a lack of management oversight which meant people did not always receive high quality person centred care. When things went wrong lessons were not always learnt and people's care plans were not updated. One person was not supported to access support from health and social care professionals following a fall until we raised this as a concern.

People knew how to complain, and the provider regularly met or communicated with people and their relatives. People told us that they felt positive about this. However, some complaints were dealt with as informal complaints and were not always recorded.

Relatives and people were involved in planning their care and in reviews of their care. People had choice about their care and were listened too.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. More information is in the full report.

Rating at last inspection: This is the first inspection of this service.

Why we inspected: This inspection was planned inspection based on the length of time since the service had registered with CQC.

Enforcement: Action we told provider to take is detailed at the end of this report.

Follow up: Following this report being published we will ask the provider to send us information on how they will make changes to ensure the rating of the service improves to at least Good. We will revisit the service in the future to check if improvements have been made.

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 always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our Effective findings below	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our Caring findings below	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Learning & Development Bureau Ltd

Detailed findings

Background to this inspection

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

Inspection team:
This inspection was carried out by one inspector.

Service and service type: This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults, younger adults, people living with dementia, mental health and physical disabilities.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was also the provider.

Notice of inspection:
We gave the service 48 hours' notice of the inspection visit because it is small, and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

What we did:
Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We sought feedback from relevant health and social care professionals and commissioners from the local authority on their experience of the service.

We visited one person who used the service and spoke to two people's relatives. We looked at three people's care plans and the recruitment records of three staff employed at the service. We viewed, policies, medicines management, complaints, meetings minutes, accidents and incidents logs, rota's and daily care logs. We spoke with the provider and three support workers.

At the inspection we asked the provider to send us some further information about training, missed and late calls and any risk assessments or care plans updated immediately after the inspection. This information was received in a timely manner. We spoke to one member of staff in more detail.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

RI: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Before the inspection there was a lack of written detailed information relating to the risks to people. This meant that staff did not have the clear guidance they needed to manage these risks safely. After the inspection the provider sent us some, but not all, detailed risk assessments to demonstrate that these were now in place.
- Where risks had been identified there was not always a detailed risk assessment in place. For example, one person had a long-term condition. There was no information to enable staff to identify when they were unwell and what to do about it. This meant there was no guidance for staff on how to support the person to remain safe and ensure consistency of care.
- One person was at risk of developing moisture sores, these are where the skin remains damp and friction can cause the skin to break down. There were no risk assessments in relation to this and no detailed information for staff on how to keep the person safe.
- Some risks were not identified in people's care plans. For example, one person had a condition that meant they needed to use an emergency medicine. This medicine was not detailed in the care plan. The person administered their medicine themselves. However, there was no information for staff about how to identify if the person was unwell and what action staff might need to take to keep the person safe. We discussed this with the provider who put an appropriate risk assessment in place immediately after the inspection.
- Where people had equipment in place this was not always detailed in the care plan. For example, some people had pressure relieving equipment to prevent them developing pressure areas. However, there was no information in the care plan about this. This meant there was a risk that staff would not know to make sure that the equipment was being used. Since the inspection the provider has put this guidance in place.
- There were incidents where manual handling had not been practiced safely. One person used equipment to move about in bed and there was no information for staff on how to use this equipment.
- Staff were sometimes very late to calls and there was no evidence people were told staff were running late. This meant people could be left waiting for care when they needed it.

Using medicines safely

- Medicines were not always managed safely. One person was supported with prompting to take their medicine and staff recorded this on a medicine administration record (MARS). The MARS we saw were complete and accurate and most were printed. However, one MARS we viewed was a very poor copy which was hard to read, and sections had been added in by hand. Where MARS are handwritten they need to be checked and signed by another member of staff to ensure that they are accurate, and they were not. We discussed this with the provider at the time of the inspection who agreed that this was an area for improvement.

● There was some information relating to supporting people with creams such as what the creams were and where to apply these. However, staff did not record when they applied creams.
● There was a lack of information about what people's medicines were for, what the side effects were and what to do if a person did not take their medicines. Since the inspection a medicine risk assessment has been completed for people managing their own medicines. This included information about what one medicine was for and when it needed to be used, but there was no information about the other medicines.
● There were no records that staff competency, to support people with their medicines, were being checked by a competent person.

Learning lessons when things go wrong
● Two incidents were recorded. However, there was no evidence that care plans had been updated as a result. For example, two people had had a fall. Neither had a risk assessment put in place to help staff to reduce the risk of further falls and no changes were made to their care plans. The provider told us they verbally updated staff, but we were not able to find evidence that this was the case.
● There was evidence there were other incidents of poor staff performance, such as staff behaving inappropriately in people's homes. However, these had not been recorded as an incident.

The provider had failed to do all that was reasonably possible to mitigate risks to people's health and safety. Medicines were not always managed safely. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were enough staff to meet people's needs.
● Staff had been recruited safely. For example, Disclosure and Barring service (DBS) checks had been completed which helped prevent unsuitable staff from working with people who could be vulnerable.
● There was evidence that staff were sometimes late to calls or did not attend calls. For example, one spot check identified staff were 45 minutes late. At the staff meeting in January lateness and attendance had been discussed as a concern. There was a lack of information regarding late or missed calls and the provider could not tell us how often calls were missed or care staff were late. At the time of the inspection the provider was putting a new call recording system in place to improve this situation. This system is now in place and will alert the office staff in real time if a care worker does not arrive on time. The provider also put in place a process to ensure that late or missed calls were responded to by office staff after 15 minutes of the carers planned arrival time.
● An out of hours process enabled staff to contact the provider if they had concerns or were unable to attend a call.

Preventing and controlling infection
● There were gloves and aprons available to staff when these were needed. There was information in people's care plans about how to reduce the risk of infection such as through hand washing. Staff had completed training in infection control.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk from abuse. There were safeguarding policies and procedures in place which included relevant information on how to report abuse.
● Staff had undertaken safeguarding training and knew how to identify abuse. Staff told us if they had concerns that they would speak to the provider. Staff were confident that the provider would report abuse.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

RI:□The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience
- Staff had received training they needed to undertake care. For example, manual handling, fluid and nutrition, safeguarding and equality and diversity. However, there were concerns relating to some staff manual handling practices.
- All staff had completed the care certificate. This is a comprehensive set of standards which cover the basics of care.
- Staff had also completed training in areas that were specific to people's needs such as diabetes awareness, person centred values and dementia awareness.
- New staff undertook one day of shadowing if they had previous experience in care but did undertake a longer period if they were new to care.
- Staff received supervision and an annual appraisal and told us they felt well supported. However, there was no evidence that staff understanding, and practice had been reviewed through medicine and manual handling competencies by an appropriately trained person.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- The provider and a member of staff visited people to undertake an assessment of their needs. The assessment included very little information on the risks to the person and included broad statements such as a person "need help with walking" but there was no information on what help was needed.
- Following this assessment visit a care plan was developed and the person was given the opportunity to review and agree to this or make amendments. However, these assessments were not used to develop a comprehensive care plan. Care plans were a list of tasks that the care worker needed to complete and contained very little information about how to support the person.
- Since the inspection the provider has redone the care plan for one person and was in the process of redoing the other two. They had added a number of risk assessments for all people. The provider has also completed falls risk assessments for 2 people and a Waterlow assessment for one person. A Waterlow assessment is a tool to identify the level of risk to a person's skin integrity.

Supporting people to live healthier lives, access healthcare services and support
- Support to access healthcare was not provided consistently. For example, two people had fallen. One person had been referred to an occupational therapist (OT) for support to reduce falls but it was not clear if the other person had. The person had a history of falls but there was no falls risk assessment in place. They had had support from an OT previously but when we visited them we saw that they would benefit from more support to reduce the risk of falls. The provider told us the person's family had been informed but could not tell us if the person had been referred to an OT. Since the inspection the provider has contacted the person's

GP to request a referral to an occupational therapist.

Supporting people to eat and drink enough to maintain a balanced diet

● Some people were supported to access food and drink. Staff supported some people by making food, assisting them to go to lunch in the complex where they lived and by supporting them to access drinks. Where a person needed encouragement to maintain hydration this was not documented in their care plan. We spoke to the provider about this who updated the care plan during the inspection.

Staff working with other agencies to provide consistent, effective, timely care

● One person was supported by care staff from another agency during the day. Staff from the Learning and Development Bureau worked jointly with this other agency to deliver some care. Staff told us that they would discuss any concerns with staff from the other agency if these had occurred when they were not there.

Ensuring consent to care and treatment in line with law and guidance

● 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.

● People can only be deprived of their liberty to receive care and treatment with appropriate legal authority.

● We checked whether the service was working within the principles of the MCA and found that they were.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

RI:□People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence
● There had been occasions where some staff had not behaved appropriately. However, where this had been identified the provider had acted to resolve the concerns.
● Staff were sometimes very late to calls. This meant that staff did not always treat people with respect as people were left waiting for their care. This could impact on people's dignity, for example when they needed support with continence.
● Some confidential information was included in people's care plans that should have been stored separately, this would be a potential risk if care plans were seen by other people, such as visitors to people's homes. We spoke to the provider about this who agreed that this was an area for improvement and that they would remove this immediately.
● Staff were able to describe how they supported people to maintain their dignity. For example, by ensuring that some areas of the body were covered when they supported a person to wash.
● Care plans were held securely in a locked office to protect people's private information. People also had a copy of their care plan in their own home.
● People were asked if they had a preference as to the gender of the care staff that supported them. This was recorded, and we saw that people's preferences were respected.
● Staff understood the importance of encouraging people to do things for themselves and supported people to maintain their independence. Staff were aware of what people could do for themselves and what areas they needed support with.

Ensuring people are well treated and supported; equality and diversity
● Some staff and the provider knew people well. For example, staff knew what items people liked to have close to them for comfort. One person was able to engage verbally but chose not to, staff knew what television programmes the person liked to watch from their interests and how they reacted to programs they enjoyed.
● Staff told us that they would communicate with people about what they were going to do before they did it. This was detailed in care plans which explained when people needed reassurance.
● People were asked about how they wanted to be supported to meet their equality and diversity needs such as support relating to their religion or sexuality. No one at the service wanted any support with these needs at this time.

Supporting people to express their views and be involved in making decisions about their care
● Where people needed support to express their views this support was provided by family members. No

one using the service needed this support.

● People told us that they were involved in planning their care. The provider met with people and their relatives regularly to discuss people's care.

● Where people wanted their family involved in their care this was recorded. People's families were involved in helping people to plan their care.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

RI:□People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- Care plans did not contain personalised information. Care plans were focused on tasks but contained very little detail about how those tasks should be carried out.
- Two people received some support from another agency and care plans had been updated to reflect this. However, not all the information was updated and there were inaccuracies. For example, staff told us that they supported one person to have lunch, but this was not included in the care plan.
- We spoke to the provider about this during the inspection and one person's care plan was updated to include more information. This included information such as what support the person needed to mobilise, what area's the person could wash for themselves and how they liked to be supported to wash. Two other care plans were in the process of being updated.
- Some staff supporting people knew them well. For example, staff knew what people liked to eat, how they liked their tea and when people wanted to do something independently. However, where staff did not know people well there was a lack of guidance in place to assist them. The provider told us that people had regular carers, but we saw that this was not always consistent and there were times when new staff provided people with support.
- The service identified people's information and communication needs by assessing them. Staff understood the Accessible Information Standard. People's communication needs were identified, recorded and highlighted in support plans. These needs were shared appropriately with others. We saw evidence that the identified information and communication needs were met for individuals. For example, the provider met with people and their relatives to explain written information where this was needed.

Improving care quality in response to complaints or concerns

- There was an up to date complaints policy in place and people told us that they knew how to complain.
- There had been no formal complaints recorded by the service. However, we identified one concern that should have been recorded as a complaint. The provider told us that this was an "informal complaint". Informal complaints were not added to a log which meant that the provider did not have oversight of these and was not analysing trends. We looked at the informal complaint and found it had been responded to appropriately.

End of life care and support

- The service was not supporting people at the end of their life and had not done so. Everyone using the service had close family support and there was no current need for the service to assist anyone to plan for the end of life. The provider was aware of their duties to support people if the need for end of life planning arose.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Continuous learning and improving care

- There was not a culture of learning within the service and learning did not lead to improvements in care.
- The provider was not learning from incidents and making improvements. Incidents of poor practice by staff such as poor manual handling and inappropriate behaviour by staff were not recorded as incidents. This meant that the provider could not monitor trends and make wider improvements where these were needed.
- There was a lack of management oversight on staff practice. For example, spot checks on staff performance were completed but there was no evidence that these included a check by a trained person on staff manual handling or medication practices to assess competence.
- There was a lack of monitoring late and missed calls. There was evidence from records and people that some calls were late or missed. However, the provider was not able to provide us with information relating to the number of late or missed calls. There was no evidence that these were analysed so that wider improvements could be made.
- Some complaints were identified by the provider as "informal complaints" and therefore had not been recorded as a complaint. This meant that the provider could not analyse trends and act accordingly.
- The provider attended local forums to meet with other providers to discuss best practice. They had completed a provider course in 2017.

Planning and promoting person-centred, high-quality care and support; and managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There were systems in place to check the quality of the service including reviewing care plans, incidents, late calls and missed calls and daily records. However, these systems had not identified the shortfalls found at this inspection.
- People's records were not always accurate or complete. Assessments of people's needs prior to them receiving care did not identify all of the risks to people.
- Care plans were not updated in response to concerns.
- Prior to the inspection risk assessments were not in place where they needed to be. Since the inspection a number or risk assessments had been completed. However, further assessments were needed for some people's needs. For example, where people had diabetes.
- There were no significant events at the service that needed to be reported to the CQC. The provider understood their responsibility to inform CQC about notifiable incidents.
- The provider was not able to provide us with information on the number of missed or late calls prior to the inspection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The provider had not ensured that the systems in place to assess, monitor and improve the quality and safety of the services provided. Complete and contemporaneous records were not kept. The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of people.

How the provider understands and acts on duty of candour responsibility
● When things had gone wrong the provider had been open and honest with people and their families. Relatives were involved in people's care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider knew people and their relatives well and met with them regularly to discuss people's support.
● Annual surveys had not been completed as no one had been using the service for over a year.

Working in partnership with others
● The provider worked with health professionals such as nurses to ensure people received joined up care.
● Two people received support from another care agency. Staff communicated regularly with the staff from the other agency.
● One person lived in a building where there was onsite low-level support. The provider and staff communicated regularly with the staff working in the building and had a positive relationship with them.

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 provider had failed to do all that was reasonably possible to mitigate risks to people's health and safety. Medicines were not always managed safely.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that the systems in place to assess, monitor and improve the quality and safety of the services provided. Complete and contemporaneous records were not kept. The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of people.