Review of compliance

Givecare Bosworth Homecare	
Region:	East Midlands
Location address:	Unit 7a Woodhouse Business Centre Woodhouse Street, Woodville Swadlincote Derbyshire DE11 8ED
Type of service:	Domiciliary care service
Date of Publication:	July 2012
Overview of the service:	Bosworth Homecare provides the regulated activity: 'Personal care' at Bosworth Homecare. Bosworth Homecare is a domiciliary care service providing care for people who need care or support at home. The service is provided within the geographical areas of Derby, Swadlincote and Melbourne.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Bosworth Homecare was not meeting one or more essential standards. Action is needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 29 May 2012, carried out a visit on 29 June 2012, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

A relative who we spoke with told us, "I have been involved in the care and welfare of my relative and we find the staff who visit are respectful of our needs and wishes".

Another relative said, "we have been able to choose the gender of the staff visiting our home and to provide personal care." This helps to maintain privacy and dignity and shows that people are involved in decisions about their care.

We were also told, "staff are careful to maintain my relatives privacy and will close the shower and room doors when providing intimate care. My relative is encouraged to do the things that they can for themselves when possible".

We saw an email from a relative who thanked staff for the support they provided to their relative and for their very caring, professional and responsible communication when talking with them over the telephone with regards to their relative's condition. They explained that their relative was reassured and this allowed them to feel they could manage and resolve the situation more easily as a result despite their distance.

What we found about the standards we reviewed and how well Bosworth Homecare was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

The provider is not compliant with this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard. People's views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The provider is not compliant with this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard.
Although people's needs were assessed their care was not always delivered in line with their individual needs as plans sometimes lacked sufficient detail.

Outcome 07: People should be protected from abuse and staff should respect their human rights

The provider is compliant with this standard. People who used services were protected from abuse, or the risk of abuse, and their human rights respected and upheld.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

The provider is compliant with this standard. People who use services were safe and their health and welfare needs were met by staff who were fit, appropriately qualified and were physically and mentally able to do their job.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

The provider is not compliant with this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard. Staff were not consistently supported to deliver care and treatment safely and to an appropriate standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The provider is not compliant with this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard. The provider had a system in place to assess and monitor the quality of service that people receive but it was not fully effective.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a

variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is non-compliant with Outcome 01: Respecting and involving people who use services. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
A relative who we spoke with told us," I have been involved in the care and welfare of my relative and we find the staff who visit are respectful of our needs and wishes".

We were told, "The care package meets our needs although we have to wait for additional funding to meet the extra needs".

We were told by the agency that staff were expected to use people's home telephone if possible so that they can remotely dial in to the office. This was used as a time checking method to monitor the length of the call and to check that the care worker was at the correct location and on time. We asked if the person with the landline minded them doing so. We were told, "I have agreed to staff using the telephone in my home to dial in only. I do feel that if I was to change my mind it would be alright with the agency".

Other evidence
We attended a staff meeting on the day of our visit. Staff told us they were able to maintain confidentiality by keeping the daily notes in the person's home and in a place decided by the person receiving the service. The person using the service or their representative and staff would know where to access it.

Staff were able to describe how they ensure people's privacy and confidentiality while they delivered care or treatment. For example, they would ensure the doors were closed and curtains used appropriately and would speak quietly about private matters and try not to talk about an individual's care in front of others.

We saw that information about care and treatment was communicated between staff by using daily notes as a means of providing information between the change of staff shifts.

It was not clear how people's dignity, independence, wishes or preferences were included in the care planning. Although decisions were being made about care there was a lack of written evidence of people who use services being at the centre of the assessment, planning and delivery of care, treatment and support as their opinion or any signed agreements did not seem to involve them as it was never mentioned in the care plans.

On listening to the staff meeting and reading the minutes of other staff meetings, we noted that staff were aware of, and able to recognise people's social and emotional needs, values and beliefs. Staff told us the care plans gave them a basic outline of what they should do but they told us they would ask the person using the service about the specific details of their care as it was not always in writing.

We read in one care plan how a person using the service needed three staff to move them using a hoist. The care plan mentioned the person was "sensitive" about their body and about their weight. However, no further details of how this person could be reassured was included. This could impact on the person using the service having reduced confidence in their care workers and further loss in their independence and dignity. We looked at another care plan and saw this was similar in the lack of detail.

When a person is new to the service they are provided with an introductory package. They were provided with information allowing them to be able to raise a concern or complaint about the service. It also told them how it would be dealt with. We did not see any mention of the local advocacy services. This service can be useful to help people to discuss their ideas before making decisions that will affect them. It may be that they had no other representatives to help them.

We asked if information about the service was available in a number of different languages or formats. We were told the agency could provide this if required although there was no evidence of this.

People using the service were provided with a questionnaire each year. This was used to provide feedback to the service on how the service was managed. However, we cannot be sure how adjustments were made in response to the feed back and as part of the decision making process for the agency. We have requested further information about this.

Our judgement
The provider is not compliant with this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard. People's views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is non-compliant with Outcome 04: Care and welfare of people who use services. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
A relative told us, "risk assessments in my home were done to make sure my electrics were safe for staff to use and general safety in the home. Manual handing for my relative was also done."

Another relative said, "we have been able to choose the gender of the staff visiting our home and to provide personal care."

Other evidence
We looked at two care plans. We saw people had a pre-assessment and a fuller assessment as part of the care process with the service. There were a number of detailed risk assessments. In both cases families were involved at the beginning of the care package but there was less written evidence of this as care continued to be provided. This means that staff would rely on verbal communications between themselves and from the person using services. This meant that any gaps in care may not be readily identified.

We saw care plans were completed but were not always tailored to meet the person's individual needs. They did not give staff sufficient detail to be able to know what to do for each person each time. For example, one person's needs included, to be changed, washed and hoisted. The instructions told staff what they needed to do. It did not explain how to approach the person, how to explain what they were going to do or how long it was expected to take. The care plan did not set out if there were any special preferences that the person would like. This meant that in practice staff with limited

experience of care could not fully meet the person's needs as they may not have considered the person's mental well being, social and emotional care needs.

Both care plans had risk assessments they were clear and easy to understand. They were reviewed by the agency. The reviews by the local authority were not regularly updated and the care package provided did not reflect the written care plans by them. This created delays in the funding for additional staff or for equipment.

Risk assessments were in place and included risks about falls or moving and handling. We saw staff were provided with procedures to follow. The care plans explained to staff what they needed to do to keep the person safe. We saw equipment was provided to help staff in their role. Hoists and specialised rolling sheets were considered. We also saw that as peoples' needs changed the response by the agency and by the sponsors of care was slower than expected. In one case it took a long while for the third staff member to be provided and funded to assist with the moving and handling needs of a person using the service in their home. However, once an additional staff member was appointed to help staff were more able to manage their moving and handling needs.

We saw other specialist agencies were also asked to help and to be involved. These included the district nurses and the occupational health teams.
We were told about changes to the care plans being made with the agreement of the person using the service where this was possible or with a family member. However, we did not always see where this was included in writing.

Daily notes were maintained by staff that related to people's needs. They were kept in people's homes and after a month or sooner returned to the office for filing.

We spoke with five staff they had a good understanding of the Deprivation of Liberty Safeguards (DoLS) and the code of practice from the Mental Capacity Act 2005 (MCA). These safeguards aim to protect people receiving care and patients in hospital from being inappropriately deprived of their liberty. The Mental Capacity Act 2005 protects people who lack capacity to make a decision for themselves because of permanent or temporary problems such as mental illness, brain injury or learning disability. If a person lacks the capacity to make a decision for themselves, staff can make a decision in their best interests. The MCA sets out care providers' responsibilities, including a two stage test of the person's capacity to make particular decisions.

Our judgement
The provider is not compliant with this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard.
Although people's needs were assessed their care was not always delivered in line with their individual needs as plans sometimes lacked sufficient detail.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
A relative told us, "I find staff to treat my home with respect."

Other evidence
Where staff are expected to handle people's money this has to be agreed in writing beforehand with the person and the managers. There was a policy for staff to follow although this was not included in the staff handbook.

The registered provider had a copy of the local authority safeguarding procedure and the provider has their own copy. We saw a copy of the training matrix this included safeguarding training for all staff. Out of 54 staff seven staff were trained in 2009 and this training may need to be refreshed. 50 staff had training in this area during 2010-2012. We spoke with five staff at a staff meeting about safeguarding and they were aware of their roles, who to contact and how to report safeguarding incidents.

Our judgement
The provider is compliant with this standard. People who used services were protected from abuse, or the risk of abuse, and their human rights respected and upheld.

Outcome 12:
Requirements relating to workers

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

The provider is compliant with Outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us
One person using the agency wrote to the agency to register their objection to a new staff member asking the person using the service what they needed do to complete their jobs. This person did not find this satisfactory and explained the new care worker should have visited their home with an experienced care worker first.

Other evidence
We saw a copy of the reply from the provider to the person who wrote the letter to them. A senior staff member was asked to accompany the new staff member and after that a promise was made by the agency to accompany and introduce new care workers to them in the future.

We examined the files of two members of staff and found all documentation in place that confirmed safe recruitment practices were being followed. However, we did not see any system in place for checking that staff from abroad were legally entitled to work in the UK or how their visas were checked. The manager explained that they have not had the opportunity to employ any non EEC staff but this would be considered further.

The manager told us that all staff had been given contracts of employment and were aware of the General Social Care Council's Code of Practice. This information is used to guide care workers in their roles. We saw that information from this document was included in the staff handbook. We looked at two staff files including a recently appointed staff member. We saw that all the required checks were in place to ensure recruitment practices for the agency were being maintained correctly. Each staff

member had a photograph of them on file and an application form and two personal references. Each file also had an enhanced Criminal Records Bureau Check and a Protection of Vulnerable Adults or Independent Adults Safeguarding first check. We saw that staff had completed a health check on their fitness to carry out their duties. All of these checks were necessary to ensure that people working with vulnerable adults were safe to work with them.

We saw staff records included a shadowing log where they worked with a senior staff member or a care worker with experience in the community. Staff told us they were not introduced to people using the service before they started to provide care to them. They told us they wore a uniform, carried their name badges with a photograph of them on it. We saw one of their badges. We noticed the name of the agency was included but the agency contact number was not provided on it. We asked staff about this and they told us people using the service could use the information in the introduction pack that they received from the agency to ring the office to check their identity. This could reduce the time provided for care and reduce the service delivered as the person using the service would need to find the introductory brochure.

Our judgement
The provider is compliant with this standard. People who use services were safe and their health and welfare needs were met by staff who were fit, appropriately qualified and were physically and mentally able to do their job.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is non-compliant with Outcome 14: Supporting staff. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
We saw an email from a relative who thanked staff for the support they provided to their relative and for their very caring, professional and responsible communication when talking with them over the telephone with regards to their relative's condition. They explained that their relative was reassured and this allowed them to feel they could manage and resolve the situation more easily as a result despite their distance.

Other evidence
Staff received the common induction standards training provided to people in the care industry and were provided with 25 hours of training and shadowing depending on experience. Emergency situations were covered and staff were informed that an in depth training would follow. A yearly performance check is completed for staff and every 3 months a spot check supervision should take place. We were told that as a result of changes to the roles of senior staff supervisions had fallen behind. We were told around half were completed.

We looked at the training matrix. Training to meet the essential standards of care included manual handling, food hygiene first aid, infection control, tissues viability, safeguarding, medication and tissue viability. Specialist training provided included a National Vocational Qualification levels two and three in care, end of life training and report writing. Staff were provided with regular updates in their training that was relevant for their role. In this way they were provided with the information and skills needed to be able to carry out the tasks involved in care.

The manager provided us with copies of the training received by staff at the agency.

We saw that the policies associated the training were reviewed and dated. We saw that a number of resources were employed to assist the learner. A training area with equipment was provided for practical learning situations such as manual handling where the use of a hoist was demonstrated.

We spoke with five staff members. Three staff explained how they shadowed or watched another care worker performing their care duties in the community.
Staff told us they felt they did not get enough shadowing and supervision. They also said some appraisals may have been missed due to the changes in their line managers. We asked the manager about this and we were told that some aspects of staff reviews may have fallen behind due to two changes of manager for some staff but that the senior care workers had started to address this now.

Our judgement
The provider is not compliant with this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard. Staff were not consistently supported to deliver care and treatment safely and to an appropriate standard.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is non-compliant with Outcome 16: Assessing and monitoring the quality of service provision. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
One relative told us, "when I needed extra care time or changes to my allotted times the agency were very helpful and provided this to help our circumstances." This person also added they knew how to make a complaint.

Other evidence
A business continuity plan dated May 2012 was seen. This included the actions staff should taken in the event of natural disasters, and other incidents that threaten to bring normal activities to a holt.

We saw the agency had made reasonable adjustments to meet people's needs in both cases and had been actively helping staff to meet people's needs by adjusting the way they managed aspects of their work.

We saw the manager was supported by a compliance team within the organisation whose role it was to check the monthly audits to monitor the quality of the service. These included contacting people to review their care within the first eight weeks of receiving care from the service. Care plans were monitored, risk assessments were checked for their updates of when changes occurred and medication records were maintained. Office records about people using the service were updated and changes in home environment of a person using the service was updated and kept in the home then transferred to the office.

Other ways of monitoring the quality of the service were seen through the supporting mechanism such as formal supervisions by the manager. However we saw that they were not all up to date and remained work in progress. We saw that there was a planned schedule of training undertaken by all staff on an annual basis. We saw minutes of staff meetings that took place every three months. Work issues were discussed and people were sent copies of the minutes. We asked about people who missed the meetings as the staff handbook mentioned that staff were expected to attend meetings. The manager explained that there should be a follow up by herself of staff who repeatedly avoid attending the meetings. We noticed that although the company's internal compliance team had visited in February 2012 the outcome and actions from the visit were missing. The summary sent to us still does not tell us this information for example 2 of the 4 people's files checked had a review in them and the 8 weekly reviews were not being completed. Out of the 4 people's files they found 2 people had their evaluation sheets missing and 1 had some dates missing. We remain unsure as to how the issues have been addressed. We have been informed that people's files remain work in progress.

Information and advice about how to make a complaint was available from the office. Information was also available in the information provided to people using the service and their relatives.

We looked at a small sample where three people were contacted by the company as part of a telephone survey. They found people receiving care were happy. They were not informed of a change of time and did not always know when care workers were coming to their home or if they had missed them coming to their home. One person told them they did not mind who visited from the agency to provide care. One person told them they did not know how to make a complaint. The action plan explained the agency should check for continuity in the care provided.
Staff were to inform people using the service if the call time has to be changed and to deliver calls at planned times. We saw that adjustments to call times were made. Staff were to make sure all people using the service know how to make a complaint. We have been sent the outcomes to the complaints that we saw.

Our judgement
The provider is not compliant with this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard. The provider had a system in place to assess and monitor the quality of service that people receive but it was not fully effective.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: The provider is not compliant with this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard. People's views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care.	
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: The provider is not compliant with this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard. Although people's needs were assessed their care was not always delivered in line with their individual needs as plans sometimes lacked sufficient detail.	
Personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met:	

	The provider is not compliant with this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard. Staff were not consistently supported to deliver care and treatment safely and to an appropriate standard.	
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: The provider is not compliant with this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard. The provider had a system in place to assess and monitor the quality of service that people receive but it was not fully effective.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 7 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
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