Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Blessings Healthcare Services Limited

Suite No 8 Shieling House, 30 Invincible Road,
Farnborough, GU14 7QU

Date of Inspection: 25 October 2013

Date of Publication: December 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Blessings Healthcare Services Limited
Registered Manager	Mrs. Maria Salome Nyeke
Overview of the service	This Domiciliary care agency is registered to provide personal care to people in their own homes. The agency currently provides this care in the Farnborough area of Hampshire.
Type of service	Domiciliary care service
Regulated activity	Personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 25 October 2013, sent a questionnaire to people who use the service and talked with people who use the service. We talked with carers and / or family members, talked with staff and reviewed information given to us by the provider.

What people told us and what we found

On the day of our visit the provider was delivering home care services to five people, two of whom required end-of-life care, one who required personal care, and two who required cleaning services. We were met by the registered manager and later joined by the proprietor.

We found that people were being asked for their permission to have care provided to them, and had the right to refuse care. We also found that the provider had a proper understanding of mental capacity issues.

We looked at the care and welfare of people who used the service and found that they and their relatives were happy with the level of care they were receiving. We also found that a proper system of care planning and management was in place.

We found that staff were properly trained in safeguarding people from abuse, and were prepared to report any instances of abuse even if this involved close colleagues.

We found that there were appropriate staffing levels in the service for the current level of demand, although we did have concerns about how the provider would cope if staff left or demand increased.

We found that the provider did not currently have a formalised and structured system of monitoring and assessing the quality of the service.. However, because of the small number of people who used the service and the 'hands-on' management approach we were satisfied that the provider was able to maintain an acceptable level of quality assurance.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

The relative we spoke with said that carers were always seeking permission from their family member regarding the care they were offering them, and always explaining what they were doing and what was going to happen next. The staff member we spoke with said they would always ask a person what they wanted, and whether there was anything else they, the carer, could do for them, even if this was not stated in the person's care plan.

The relative said that if their family member refused to co-operate with a carer, which had happened a few times, the carer would call them and they would discuss how to approach the situation. They gave an example of their family member not wanting to eat their evening meal because a different staff member to the one they had been expecting had turned up. The staff member we spoke with said that if a person refused care they would try and encourage them to co-operate but if they continued to refuse they would not force anything onto them. Instead the staff member would contact the manager and advise her of the situation.

From our conversations with the relative and the staff member we were satisfied that the provider was ensuring that people who used the service or their representatives were giving consent to care on a day to day basis, and would respect the right of people to refuse care.

The staff member said that none of the people they cared for were able to make an informed decision about the care they received. We asked the staff member what they would do if an important decision had to be made which would need the person's consent. They said they would inform the manager and let the person's next of kin know. The staff member said if a person's mental state had deteriorated to the point they could no longer communicate their needs the staff member would continue to helping them unless they refused but would inform the manager and the next-of-kin. They said they would always try to do the best for the people who used the service.

We were given a copy of the provider's Mental Capacity Act policy and noted that this included the principles of mental capacity; the concept of "reasonable belief", which relates to the provision of day to day care for a person who lacks capacity to make decisions; the concept of "best interest", which relates to decisions made on behalf of person who is deemed to lack mental capacity; the process of assessing mental capacity; the role of Independent Mental Capacity Advocates (IMCAs), who can support a person who lacks capacity; and the concepts of Lasting Power of Attorney and Enduring Power Attorney, which relate to another person having the legal authority to make decisions on behalf of another person.

The provider told us that they did not offer mental capacity training to staff at the moment but would look at making this part of the mandatory staff training programme.

On the basis of our conversations with the staff member and the manager, and on the information provided we were satisfied that the provider understood the principles of mental capacity and would involve all relevant stakeholders should there be a need to take decisions on behalf of people who used the service.

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We spoke with one person who used the service who told us the service was very good and that someone from the provider had been coming in regularly to clean their flat. They said the staff member was very respectful and polite and knew exactly what to do. The person said the staff member took very special care over what they would do and they (the person) would have no hesitation in recommending the service to anybody else.

We spoke with a relative of a person who used the service and they told us they were very pleased with the level of service. They said their family member had regular visits from carers who helped them with personal care, meals and getting up and going to bed. The relative said they thought one particular strength of the service was the calibre of the staff it recruited and the fact they were very flexible in working with the relative's family member. The relative said that carers did not "just plonk food down and go" and they treated the family member's flat like a proper home, for example by making sure they kept areas clean. They said that their family member got on very well with the carers who were supporting them. They said the manager would often accompany the carers on visits and make sure they were doing their work properly. They said carers would never rush in their work and would find ways to use their time effectively. They said that they thought it helped that two of the staff came from a culture where elders were naturally respected.

The relative said they thought having the same three carers, including the manager, supporting their family member was very helpful, and they thought that staff were respectful of the people they were working with. They said they were going to be going away soon for a while and had no worries about leaving their family member in the hands of the carers. The relative finished by saying: "The staff are excellent – long may it continue!"

Our conversations with one of the people who used the service and the relative of another person demonstrated to us that people were being properly looked after, and that people and their relatives were generally happy with the service.

We looked at how people's needs were assessed, managed and reviewed. We looked at the care plans of the three people who were receiving personal care in their homes. The provider explained that the other two people, who were being offered a cleaning service,

had signed a short contract for these services.

We noted that the care plans consisted of a page of basic information about the person followed by a daily schedule specifying the tasks to be carried out and the days and times of those tasks. This was followed by a set of risk assessments tailored to the needs of each person, for example cognition, psychological and emotional needs, continence, tissue viability and breathing. Each risk assessment specified the degree of risk, the nature of the risk, and how the risk was to be prevented. There was also a brief environmental risk assessment which looked at any identified hazards in the person's home.

The provider told us that some people's initial assessments were sent to them by the referring agency, for example the local Clinical Commissioning Group or the Local Authority. In other cases the manager and one of the care staff would visit the prospective client and talk with them and their relatives, friends or neighbours to find out more about them, their needs, preferences and preferred visit times. The manager would then type up the draft assessment and take it back to the person for their approval. A final version, verified by the person, would then be produced.

The relative we spoke with said they had been closely involved in putting their family member's care plan together and continued to work closely with the provider, reviewing the care plan on an ongoing basis. They said that they worked closely with manager and met periodically with her to review their family member's care plan. They said carers also left detailed notes in the home of how they had supported the person and the relative always read these notes, which they found helpful.

The staff member we spoke with said they would always keep daily notes of the care they gave to the person, and would always follow the person's care plan. If any changes had to be made to the care plan this would be the responsibility of the manager. We were shown a copy of a person's daily log, which was a description of the care offered to the person and their state of health, and also included copies of food charts and body maps. We noted that the log had been kept up to date. The provider told us that daily logs were normally kept in people's houses.

Our conversations with the manager, the staff member and the relative of one of the people who used the service, and our review of care plans, demonstrated to us that people's needs were being properly assessed, managed and reviewed on a regular basis.

We asked about the plans the provider had for dealing with emergencies and interruptions to the service. We were given a copy of the provider's business continuity plan and noted that it included comprehensive impact and risk assessments on key processes and functions of the service, which aimed at identifying which parts of the service would be most affected by an emergency or interruption of service and how these risk should be managed. The plan also included responses to particular emergencies, for example loss of IT, lack of staff, severe weather conditions, and strategies for recovering from emergency situations.

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

The person we spoke with said they felt safe having the staff member in their house. The relative we spoke with said that they thought their family member was safe.

We asked the staff member we spoke with if they had done training in safeguarding vulnerable adults. They said that they had and were able to tell us about different types of abuse including physical, emotional, sexual and racial. They were also able to describe the signs of abuse, for example bruising and changes in a person's behaviour. The staff member said they had read the provider's safeguarding policy and thought it was a useful document because it helped staff protect themselves as well as the people who used the service. We look at two staff members' records and noted that they had both done safeguarding training.

The manager showed us the DVDs which were used as the basis of the provider's safeguarding training. We noted that the training programme covered a range of safeguarding issues including definitions of safeguarding and abuse, key legislation relating to safeguarding, who has responsibility for reporting and investigating abuse, whistleblowing, and the use of physical intervention to prevent abuse.

We looked at the provider's safeguarding policy and noted that it included a definition of abuse; factors to consider when assessing and reporting abuse; the procedures for dealing with abuse; the process for investigating allegations of abuse; and key contacts regarding safeguarding, which included Hampshire Adult Services, The Safeguarding Professional Advice line, and the CQC. The manager said the service used the Hampshire Adult Services Safeguarding Guidance for Provider Services as a framework for their own safeguarding policy and procedures.

The staff member said that if a person who used the service told them that they had been abused by another carer they would reassure the person that they would be looked after and invite them to tell the staff member what had happened. However, they would not try and force the person to tell them or ask them leading questions. They would also report the allegation to the manager.

From our conversations with staff and our review of safeguarding information we were satisfied that staff would be able to identify abuse and know the procedures for reporting it. Furthermore, we were satisfied that staff would have no hesitation in reporting any instances of abuse or suspected abuse, even if these involved close staff colleagues

They staff member said they had read the provider's whistleblowing policy and thought it would help support them if they had to report any wrongdoing. The staff member said they saw it as their duty to report any wrong doing and thought the provider would take them seriously. We looked at the provider's whistleblowing policy and noted that it focused mainly on the principles of whistleblowing, including that employees would not face victimisation if they reported malpractice in the organisation, and the duty of disclosure if a staff member suspected or witnessed malpractice.

From our conversations with staff and our review of the whistleblowing policy we were satisfied that staff would feel supported by management and have no fear of recrimination if they were to report abuse or allegations of abuse.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough skilled and experienced staff to meet people's needs.

Reasons for our judgement

We spoke to one staff member who told us that they had worked for the provider for one year doing ten hours a week care work. They said they had no formal care qualifications but had done all the induction training. The staff member said they thought there were enough staff to meet people's needs. They said if they were unable to make a visit they would contact a colleague who would be able to cover for them. The manager said that if a staff member was off sick or couldn't make a visit she would step in.

We noted that each care plan of the five people who currently used the service had a full schedule of care covered by the two staff members and the manager. This specified the days and times that care was to be provided and by whom. We were also given a copy of the current rota for a particular person's care which showed us that care was being delivered in line with the requirements of the person's care plan.

When we arrived for the visit the manager told us that at the moment the service employed two staff, but both herself and the provider were also very 'hands on' and involved in day to day care provision. The manager said they had recently been awarded a major home care contract by the local authority and were in the process of recruiting ten to twelve new staff so they could meet the contract.

However, the manager told us that there had been a serious delay in the local authority confirming the contract and consequently the provider had not been given any work from the local authority. This had meant that the two existing staff members were started to get worried about the future of the organisation, and a third staff member who had been employed had already left. On the day of our visit the manager was due to meet with the two remaining staff to try and reassure them about the future of the organisation, but one staff member was unable to stay for the meeting and the other one left after speaking with us.

Because the provider was unable to give us assurances that the two current staff members would be staying in the light of the uncertainties about the new contract we asked the provider to tell us about their contingency plans for ensuring that they would be able to continue to provide care for the existing people who used the service. The provider told us, and later confirmed in writing, that it currently had twelve staff on its register, including the manager and the proprietor, but because of limited demand they had

effectively been using two staff who had been looking after a long standing person who used the service. Two of the other people who used the service required end-of-life care, and the other two only required cleaning services.

In order to ensure continuity of service in the eventuality of the two staff members leaving the provider stated that everyone in the organisation was trained to provide personal care, including the management team and the office administrator. Furthermore, the provider had two bank (sessional) staff they could call upon if necessary. The provider stated that they were currently in the process of recruiting new staff in readiness for the new contract, and three of these applicants were waiting to be cleared by the DBS (Disclosure and Barring Service). The provider also stated that the other staff members on their register had asked to be contacted when there was the likelihood of more work. Finally, the provider stated that they could also use the services of local employment agencies to cover current work or to meet an increase in demand.

Although the provider acknowledged that they were facing potential difficulties in retaining staff because of the uncertainty about the future of the company, on the basis of the information provided and the discussion we had with the manager and the proprietor we were satisfied that the provider would still be able to meet the needs of the current people who used the service.

Assessing and monitoring the quality of service provision ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

The provider was developing an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

The person we spoke with said they couldn't remember if the manger had asked their views on the service. However, they said that if they did have any problems they would have no hesitation in calling the manager. The staff member we spoke with said they met regularly with the manager which meant they could feed back any concerns they might have. They said they also attended regular staff meetings two or three times a month. We asked to see copies of minutes of these meetings but the provider told us they were not being currently minuted.

We looked at complaints as a means of feedback and noted that the provider had had three complaints over the last twelve months. One of these was about food, one about the standard of cleaning, and one about missing items. We noted that each complaint record contained a description of the complaint, how it was investigated and the outcome.

We asked how the provider monitored the quality of the service on a regular basis. The manager told us that she carried out regular spot checks on the service by visiting the homes and that these were recorded in the daily notes. She said she would observe how staff were working, and also ask people what they thought of the service. However, when we looked at the daily notes we could not see any references to spot checks or a record of people's feedback. When we put this to the manager and the provider they acknowledged that it would be a good idea to record all this information.

The provider said that at the moment they did not have a formal and structured way of auditing and reviewing the service. They agreed to send us their proposals for achieving this following our visit. The proposals stated that the provider would regularly assess and monitor the quality of its services; would identify and manage risks relating to health welfare and safety of people who used the service and others who might be at risk; and get professional advice about how to run the service safely, when the provider did not have such knowledge and expertise themselves.

In terms of how these activities would be carried out in practice, proposals included gaining regular feedback from people who used the service and their relatives; speaking to staff to ascertain the challenges they faced in their work; conducting monthly visits to

people who use the service to ensure their needs were being met, followed by a report on the findings of the visit; and an annual satisfaction survey for people who used the service.

The provider also provided us with a quality assurance audit report template which was designed to record the outcome of the proposed monthly visits. We noted that the template included sections on discussions with people who used the service and their relatives; interviews with staff; key findings from looking at complaints records; commentary of progress made on planned improvements; and action plans agreed as a result of the visits, including timescales and the lead staff member to take the actions forward.

Although we expressed concerns to the provider that they were not currently assessing and monitoring the quality of the service in any systematic way and were not recording any of their findings, we acknowledged that with such a small number of people using the service and such a small staff team, the manager and the proprietor were able to keep a close eye on service quality. However, we also pointed out that any increase in demand for their services might create problems with regard to quality assurance. Because the provider acknowledged the need for a more structured quality assurance system and showed us their proposals for implementing this, we were satisfied that they would be able to monitor and assess the quality of the service effectively should they secure more work.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - 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.

Moderate impact - 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.

Major impact - 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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk