Shaudrey Limited

Essex

Inspection report

16 Lockwell Road
Dagenham
Essex
RM10 7RE

Tel: 02082625715
Website: www.realcarehealthservices.com

Date of inspection visit:
08 October 2018

Date of publication:
28 December 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on the 8 October 2018 and was announced. This was the first inspection of the service.

This service is a domiciliary care agency. It provides personal care to people living in their own houses. It is registered to provide a service to people who misuse drugs and alcohol, children, older adults, younger adults, people with mental health issues, people living with dementia and people with physical disabilities. A small number of people were using the service at the time of our inspection.

The service did not have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found two breaches of regulations during this inspection. This was because medicines were not managed in a safe way and the service lacked quality assurance methods and monitoring systems that might improve the service for people or make the service better or more efficient. The provider did not record meetings with people or relatives as best practice would dictate. The provider did not seek feedback from people or relatives. You can see what action we have asked the provider to take at the end of the full version of this report.

We have also made one recommendation about the supervision of staff.

There were appropriate safeguarding procedures in place and people told us they felt safe using the service. Risk assessments provided information about how to support people and mitigated against risk and harm. There were sufficient staff working at the service to meet people's needs and recruitment procedures aimed at keeping people safe. Staff understood infection control issues and used protective clothing when necessary.

People's needs were assessed before the service worked with them. This meant the service determined whether they could provide the right care for people. Staff received induction training before starting work at the service and had access to regular training that helped them support people's needs. The service operated within the principles of the Mental Capacity Act 2005 and staff understood the need to seek consent from people. The service supported people to access health care professionals when required.

People were supported by the same staff so they could build good relationships. People were treated in a compassionate manner by staff and where possible were supported to maintain their independence. People's privacy and dignity was respected.

Care plans were detailed and personalised to meet people's individual needs and had clear instructions for

staff to provide the right care. The service had a complaints procedure in place and people knew how to make a complaint. The service had the ability to be able to provide end of life care.

People and staff spoke positively about the nominated individual who was managing the service. The nominated individual had links in to peer providers. People, relatives and staff knew what to expect from the service as this was set out in the service user guide and the service's mission statement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The service did not maintain records of medicine administration nor did they complete observations of staff administering medicines.

People at the service felt safe and there were safeguarding policies and procedures in place.

The service completed risk assessments for people that were detailed and mitigated against risk.

There were enough staff to support people and staff were recruited safely.

There were robust infection control measures in place to protect people from infection.

Is the service effective?

Good

The service was effective.

Peoples needs were assessed before being cared so the service knew they could provide the right support for them.

Staff at the service were trained to do their jobs and supported by the management team through informal supervision.

People were supported to eat and drink.

Staff communicated effectively with each other to support people.

Staff at the service understood the principles of the mental capacity act and knew to seek consent before supporting people.

Is the service caring?

Good

The service was caring.

Staff treated people kindly and compassionately.

People's privacy and dignity was respected.

People were supported to be involved with decisions about their care.

Is the service responsive?

Good

The service was responsive.

People had personalised care plans that were detailed and provided staff with clear instructions on how to work with people.

There was a complaints process for people to make complaints should they need to.

The service was not supporting anyone at end of life but the foundation for doing so was in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service lacked quality assurance methods and monitoring systems which made it difficult for them to improve.

The service did not record meetings with people or relatives and did not seek feedback from them.

The service did not have a registered manager in place but everyone using the service thought positively about the nominated individual who was managing day to day activities at the service.

Essex

Detailed findings

Background to this inspection

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

This announced inspection took place on 8 October 2018 and was completed by one inspector. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to facilitate our inspection visit.

Before the inspection we reviewed the information we already held about this service including details of its registration reports and any notifications of significant incidents the provider had sent us. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority to get their views on the service.

On the day of inspection, we spoke with the nominated individual. Afterwards we spoke with three further staff by telephone, two care assistants and one nurse. We also spoke by telephone with a person using the service and a relative of a person who used the service. We reviewed the care records relating to all people who used the service at the time of inspection and the recruitment and training records of five staff. We checked policies and procedures and minutes of team meetings. We examined the quality assurance and monitoring systems in place.

Requires Improvement

Is the service safe?

Our findings

The provider did not always have safe practice with respect to the administration of medicines. The provider was unable to show us records of the medicines they administered due to a shared arrangement with another provider. However; staff working for this service had responsibility for administering medicines and there were no systems of oversight or management of this by the provider. Whilst the provider assured us there had been no medicines errors, there was a lack of evidence to demonstrate that medicines had been administered safely. The nominated individual told us that in future they would arrange for copies of the MAR charts to be kept.

The provider informed us that whilst staff had received medicines training with other training providers, they had recently agreed a new contract with a training company who would assist them with their medicines administrations and also help them to set up a system for competency checks and observations of staff administering medicines– something the service was not currently doing.

The provider had a medication policy in place and told us that the policy was kept in people's folders in their homes. We also saw training records for staff on medicines. One staff member told us, "Before you start, you have a mar chart in the house, you check right patient, right dose, right meds and whatever it is prescribed you know why it is given."

The provider failed to ensure there were effective systems in place for the proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on safe care and treatment.

People and their relatives told us they felt using the service. A person told us, "Safe as I had been [before using the service]." A relative told us, "I'm over protective and I'm more than happy with the staff."

There were safeguarding systems in place to protect people from abuse. There were policies and procedures to support staff in their role with regard to safeguarding. We saw flow charts that helped with decision making around safeguarding and clearly indicated the responsibility of employees to safeguard vulnerable adults and children. The nominated individual told us that copies of the safeguarding policy were kept in all people's care plans within their homes. The nominated individual understood their responsibility to with regard to safeguarding. There had been no safeguarding allegations or concerns raised.

We saw that staff had completed safeguarding training. One staff member told us, "Safeguarding means making sure [person] is safe and if there are signs of abuse, for example physical, financial abuse etc. I ask my manager to get involved or I call police or safeguarding team in the borough." This meant if people were being abused or at risk of abuse, staff at the service would know what to do to support them.

The risks people faced were recorded accurately in risk assessments. A staff member told us, "[Registered manager] created risks assessments before I came in but we will do reviews together – if there is any risk I will inform [registered manager]." The risk assessments also detailed information on how mitigate risks and

covered many aspects of people's lives such as their physical health, communication and mobilisation. We also saw personalised risk assessments that covered specific areas of people's lives such as external activities taking place in specific locations. This meant that risk to people were mitigated against and they were supported to live a full a life as possible.

People and staff told us there were sufficient numbers of staff. One staff member told us, "Yes we have more than enough and we're able to cover the hours." We saw there was enough staff employed to meet people's needs. The nominated individual showed us a new electronic system they will set up over the next few months that will assist plan people's care hours more efficiently. The nominated individual also informed us that they were able to cover shifts if necessary. This meant that there were enough staff working to support people.

We looked at four staff recruitment files. The provider had completed all the necessary checks to ensure staff were suitable to work with children and vulnerable adults. This included previous employment, qualifications, photographic id to verify who they were and Disclosure Barring Service checks (DBS). DBS certificates indicate whether individuals have any criminal records and or whether they are placed on lists stating they are unsuitable to work with children or vulnerable adults. The provider had also taken steps to check the professional registration of the nurses they employed. This meant the service had robust recruitment procedures in place to ensure staff employed were suitable to work with vulnerable people.

People and relatives told us that the provider recruited staff who were able to support them. One relative told us about staff's suitability, saying, "Yes, I look for that before taking them on board– I interview them personally when they come on - they need to have the right passion, people need to shadow and have their right training before they work with [person]." This meant that people and their relatives were supported by staff who were suitably experienced to carry out their roles.
People were protected by the prevention and spread of infection. There were robust policies and procedures in place for staff to follow. Staff had received training and knew what to do to prevent the spread of infection. One staff member told us, "We have gloves, hand washing the most important thing…wearing Personal Protective Equipment - aprons, gloves etc." We saw cleaning records of clinical equipment being cleaned daily. This meant it was less likely for people to be infected through their daily care.

The nominated individual told us that lessons would be learned if things went wrong. There was an accident and incident reporting policy that staff were aware of and we were told that accidents and incidents forms and protocol were placed in peoples care plans in their homes. However, as there had been no incidents or accidents recorded the service did not maintain a log – they were advised to create one. The nominated individual also told us that they would investigate any incidents, refer onwards if necessary to the relevant authority or institution, notify CQC if necessary and lessons learned would be emailed to all carers so that lessons could be shared.

Good

Is the service effective?

Our findings

People's needs were assessed before they started using the service. This meant that the service could tell whether it could meet their needs or not. Assessments were scored to indicate whether the need was low support or high support. Assessments covered areas of need such as nutrition, communication, pain, mobility, culture and education as well as many other areas that would assist the provider in knowing people's needs. A relative told us that the service assessed for and offered, "Holistic care."

The service made sure their staff had the right mix of skills and knowledge to provide effective support. Staff received an induction when they joined the service. One staff member told us, "We had induction – showing us all about how it works, where to go, what to do. We had to read policies and procedures and these were in the client's folders too. Always shadowing too." As part of their induction all staff would meet and greet the people they cared for and their relatives and would shadow existing employees on shift to learn how to support individuals.

Staff received training to carry out their roles. One staff told us, "We've just done some, trachy [tracheostomy – windpipe opening and equipment], PEG [Percutaneous Endoscopic Gastronomy - assisted feeding through tube into the stomach] and nebulizer [equipment to assist medication into the lungs]. It was refresher for me." Another staff member said, "we do mandatory training too." Records indicated that staff completed training specific to their roles. We saw the provider had arranged training on ventilation and peg feeding (peg feeding is for people who have difficulty eating normally and usually requires a feeding tube placed directly into the stomach) that week, we spoke to staff members the following week who confirmed they had taken the training. All care staff working for the provider had completed or were in the process of completing the Care Certificate whilst nurses were doing care planning and assessment training. The provider also told us they had plans to develop someone into a trainer so that they could train their colleagues.

The nominated individual told us that they had one to one informal supervisions over the phone and occasionally in person with staff. They had not completed any appraisals with employees. The company's policy on supervision stated that, "Staff will receive the support, training, professional development, supervision and appraisals that are necessary to carry out their role and responsibilities." It also added that supervision was, "Planned and recorded." This showed that the service was not always providing and recoding supervision for their staff. The nominated individual told us they would begin to do so once people had been in service for a year.

We have recommended that the provider follow best practice guidelines and hold and record supervisions with staff regularly.

People were supported to eat and drink enough as and when appropriate. Staff had been trained to use specific clinical equipment, such as PEG, to assist feeding for those who had difficulties. We saw that where this occurred care plans gave directions as to what should happen and notes recorded what happened. People and their relatives told us that that staff assisted them in these matters where necessary.

Staff communicated effectively with each other to ensure people's needs were met. Staff kept daily communication notes to convey information from shift to shift. Note templates were broken down into different sections that mirrored the care plans and assessments. These different sections covered different aspects of people's needs, such as breathing, nutrition, mobility, elimination as well as other areas. Notes we saw were detailed and gave good account of what information should be passed on, for example, "Breathing - Breathing in room, SAT is stable, nebulizer given as required." We also saw that the provider had created paperwork dedicated for handing over specific clinical information. This meant staff knew where to find specific information about people's clinical needs.

People were supported to live healthier lives. Some staff at the service were nurses and supported people with their clinical health needs. Where appropriate nurses and carers liaised with GPs, district nurses and health services to support the people they cared for. Information about health care needs or changes were recorded in the communications notes and changes made to care plans if necessary. One relative told us, "They are nurses – if I am not able to attend they will represent at a GP appointment for me or speak to the consultant."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The nominated individual or their staff did not carry out mental capacity assessments of people and sought assistance from the local authority or NHS in this regard. The service was not providing a service to anyone with a lack of capacity at adult age. The nominated individual and staff knew about the mental capacity and what it meant for people. Staff had received training on mental capacity. Staff told us they seek consent before working with people and that where people lacked capacity they worked in their best interests. One staff member said, "We work in their best interests." Another staff member said, " Before I do anything I will talk to them – and tell them what I am doing – anything I am doing I seek consent."

Good

Is the service caring?

Our findings

People and their relatives told us that they were treated with kindness and respect. A relative told us, "They have empathy for what they do." They continued, "They always communicate with [person] and tell them what they are going to do. Although [person] can't communicate verbally you can tell from their reaction they are pleased to see the care staff," Staff had learned to read non-verbal cues to assist a person they supported and in this way knew their likes and dislikes. The same relative told us that people had the same regular care staff which meant that staff and people knew each other and had the opportunity to build good relationships with each other.

Staff knew the people they cared for. One staff member told us, "First of all when I met [person] I asked them what they wanted me to call them, how they want to be addressed." Another staff member told us, "we look at likes and dislikes." Another staff member said, "We get to know [person] and we can tell – there would be movements [to demonstrate what] they like and don't like." Staff told us they were aware of people's preferences through communicating with them or their relatives and these were reflected in care plans. This meant that people were cared for by staff who knew what they liked and disliked.

Staff treated people respectfully. One staff member told us, "[treating with respect means] for example, during personal care, look after their privacy, shutting doors, having them covered." Staff told us that they cared for people by treating them in a person-centred manner, "how they wanted to be treated" and that if they needed or wanted time alone then they would be given it. This showed staff understood people's right to dignity and aimed to demonstrate it in the care they provided.
Staff had appropriate concern for people's wellbeing. A relative told us, "They give [person] time after they have fits. [Staff] sometimes go over time if it's necessary." They continued, "They do the right thing." Staff also told us they ensure the people they work with are ok by monitoring them and recording this information in daily notes. Records showed appropriate concern for wellbeing was noted. This meant people were looked after.

Care plans also demonstrated that people were respected and treated with kindness. One example stated, "Treat [person] with respect and ensure that eye contact is made when asking for consent." People's equality, diversity and human rights needs were met. The provider understood equality and human rights. The provider had an Equality and human rights policy and procedure that outlined their support for people by promoting and protecting their rights. Staff at the service understood the need to promote equality and diversity and that people's human rights should be protected. One staff member told us, "We have different people with different cultures and religions… it's about taking their religion into consideration."

Staff provided support to people and their relatives to engage with other services. A relative told us that staff had represented their interests at meetings with healthcare providers. A staff member told us that "Yes – we deal with GPs etc if some clients have appointments, we arrange all these things, chiropody etc with health care professionals." This meant that staff were happy and able to advocate for people and their relatives to ensure they received appropriate support where necessary.

The service supported people to be involved in decisions about their care. Care plans we saw were signed by people or relatives involved in their care. We saw that reviews of care plans were completed every six months or when necessary. The nominated individual attended meetings with relatives and people to review care and ensure their views were expressed.

People's privacy and dignity was respected and their independence promoted. The provider had a privacy policy that stated its purpose was to "support the human rights of the service user." There was also a service user guide that stated, "All service users clients have the right to be alone or undisturbed and to be free from public attention or intrusion in to their private affairs. The staff of the agency are guests in the service user/client's residence". Staff told us that they followed this guidance. One staff member said, "Some patients they may wish to be left on their own in their room ….. If they want to go to toilet they can call us when they need or if their family members want to be with them we give them that time."

The service kept people's confidential information secure. Confidential information about people was kept either in locked cupboards in a locked office or on a password protected computer. This meant that people were assured that no one could access their private information who wasn't supposed to.

Good

Is the service responsive?

Our findings

People had personalised care plans that identified their needs and directed staff how to work with them as to their preference. Care plans were detailed and clinical where necessary. People's care plans highlighted their likes and dislikes. With this information staff were able to get to know people and thereby provide them with better care. Care plans set out what challenges a person faced, what objectives there were in relation to those challenges and how to provide care specific to that challenge. For example, we saw records of a physical disorder someone suffered with. The care plan indicated what were the symptoms and signs of the disorder, what staff should do when they suspected the person was suffering with symptoms of the disorder and how they should treat the person.

We also noted that where appropriate the care plans had direct quotes from health care professionals and specific directions for when symptoms went on for given amounts of time. This meant that staff knew how to work to with people in ways that they or their relatives wanted and or had been directed to by healthcare professionals.

People were supported to attend and participate in activities. A relative told us, "They'll often go to the park together." Records indicated that people were supported to leave their homes and do things they enjoyed. The provider would often create risk assessments to ensure people were safe for this to happen. This meant the people were supported to live more fulfilled and meaningful lives.

Whilst still not fully utilised, the provider had invested in technology that would assist staff provide more timely care and support. The technology, an app, looked easy to use and would give staff access to people's information and also company policies and procedures. This meant that staff would be able to support people more efficiently, placing more time on care than on information gathering.

The service had not received any complaints. People and relatives confirmed this but told us they felt confident they would know how to do so if necessary and that the staff would respond to complaints appropriately. A person told us, "Yes, I know who to complain to." The service had a complaints policy that sought to promote the raising of complaints in a positive light and protect complainants in the process. The nominated individual assured us they would log complaints once they were received and investigate them. This meant that improvements could be made and lessons learned should complaints be received.

The service was not supporting anyone at the end of life. We were informed that people using the service, or their relatives did not wish to complete advanced care plans at this time. However, there were policies to support people at end of life and the nominated individual told us they would pursue end of life training were they to care for someone at end of life.

Requires Improvement

Is the service well-led?

Our findings

The service lacked effective quality assurance processes and monitoring systems. The provider's good governance policy and procedure stated its purpose was, "To establish a framework" which "Can demonstrate accountability for continuously improving the quality of services." We asked the nominated individual how they monitored the work staff did, such as through audits or regular checks, and they told us they did not record any. This meant the quality of care at the service was not monitored, leaving limited opportunity for it to improve. We expect providers to monitor the quality of their services so that people using the services receive the best care possible. When this does not happen it contributes to our judgement that the service is not being well led.

The provider did not have systems in place to monitor the provision of care at the service. For example, they did not track staff training and supervision. The nominated individual informed us that they did have regular communication with people, their relatives and staff and felt assured they knew what was going on. They also told us about a new electronic system they were in the process of transferring to which would assist their tracking and monitoring of people's and staff needs They hoped the system would be operational within a month of our inspection. Staff confirmed that the nominated individual did have frequent communication with them and were also expecting a new online system to be put in place. The nominated individual also sent us an action plan following inspection that showed they had listened to our feedback and were in the process of setting up monitoring systems. However, the lack of quality assurance monitoring at inspection made it difficult to identify shortfalls or areas for improvement.

People and their relatives told us that they held meetings with the provider about their care. One relative said, "[Staff] will come and give review, they check to see clients given the right things." We saw that care plans had been amended after these meetings. However, the provider kept no records of these meetings. We also noted that there had been no staff meetings since the service began in June 2017. The nominated individual explained that it was difficult to bring people, relatives and or staff all together. We would expect providers to keep records of meetings they hold so that people and their relatives wishes can be followed correctly and referred to at later dates. We would also expect staff to meet and communicate with their staff teams to share important information. The provider told us they would record meetings with people and relatives in future and send out emails to staff to ensure they did not miss any relevant updates about people using the service and or service developments.

The provider had not asked people, relatives or staff to complete surveys and/ or provide feedback about the service. The nominated individual, people and their relatives confirmed this. In not asking people and their relatives to complete surveys or provide feedback the provider lost the opportunity to find out where they might be able to improve on the care they provide. It also limits the ways in which people are offered a 'voice' in their care and treatment. We would expect providers to listen to the people using their services and use the information they receive to improve people's care. The provider had no plans to request surveys before we inspected, however, following our feedback they said they would begin to do so.

The provider had failed to implement systems to assess, monitor and improve the quality of care at the

service. This meant people were not being provided with the best care possible as there were very few ways the provider could monitor and improve the care they provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on good governance.

Following the inspection, the nominated individual provided us with an action plan, audit tool and business contingency plan. This meant they had acted on the feedback we had provided at inspection and sought to improve their service in a timely manner.

The service did not have a registered manager in place. The nominated individual had initially applied to take on this role but decided to withdraw their application following our inspection. They were hoping to fill the position with someone with previous experience of being a registered manager. People, relatives and staff viewed the nominated individual as the manager of the service and were positive about them. A relative told us, "Its managed really well… [nominated individual] understands me and our needs." A staff member said, "[nominated individual] is good she is always supportive."

The work culture and ethos at the service was positive. Staff felt supported in their roles and that the nominated individual ran the service well. A relative said, "They have the best staff." A staff member said, "Yes [nominated individual] are good. It's their business – they need to be good! So far they have treated us very well." The service had a service user guide, mission statement and statement of purpose that set out clear vision for high quality care and to support people. The mission statement said, "To bring exceptional client centred health care into the home with innovation and compassion." This meant people, relatives and staff had positive expectations and views of the service.

The nominated individual informed us that they received peer support from fellow providers on an informal basis and that they were in the process of completing a management and leadership qualification. They also informed us of their interest in attending social care conferences and joining local registered manager networks. This demonstrated the provider's commitment to maintaining good practice and forging local links, which would benefit people using the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was no proper and safe management of medicines. In particular: The registered person did not have oversight of medicine administration records and staff had been assessed for competence in medicine administration.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: The provider did not keep records of meetings with people and or relatives regarding their care. The provider did not complete audits or quality assurance monitoring.