Respect Care Services Limited

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## Inspection report

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07 October 2016
10 October 2016

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

We conducted an inspection of Respect Care Services on 5, 6, 7 and 10 October 2016. The inspection was announced. We gave the provider 48 hours' notice to ensure the key people we needed to speak with were available. At our last inspection on 24 January 2014 the service was meeting the regulations looked at. The service provides care and support to people living in their own homes. There were 400 people using the service when we visited.

There was a registered manager at the service. 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.

Risk assessments and care plans contained some information for staff, but we saw some examples of incomplete or inconsistent record keeping that could have placed people at risk of avoidable harm.

Medicines were accurately recorded when care workers prompted people to take their medicines. We were told by the registered manager that she checked medicines records upon receipt in the office and archived them immediately upon checking them.

Safeguarding adults from abuse procedures were robust and staff understood how to safeguard people they supported. Staff had received safeguarding adults training and were able to explain the possible signs of abuse as well as the correct procedure to follow if they had concerns.

Staff demonstrated knowledge of their responsibilities under the Mental Capacity Act 2005. However, records did not always contain details of people's capacity and senior staff did not ascertain whether signatories to documentation had the legal authority to make decisions. Some records had not been signed to demonstrate that people had given their consent to their care and support.

Staff demonstrated an understanding of people's life histories and current circumstances and supported people to meet their individual needs in a caring way. However, care records contained very limited details about people's needs or preferences.

Recruitment procedures ensured that only staff who were suitable, worked within the service. There was an induction programme for new staff, which prepared them for their role.

Care workers were provided with appropriate training to help them carry out their duties. Care workers received regular supervision of their performance, but appraisals were not conducted regularly. There were enough staff employed to meet people's needs.

People were supported to maintain a balanced, nutritious diet where this formed part of their package of

care. However, people's care plans did not always contain sufficient information for staff about how to meet people's needs in relation to their health and nutrition.

People using the service and staff gave positive feedback about the registered manager and told us they provided feedback about the service. They knew how to make complaints and told us they felt listened to and there was a complaints policy and procedure in place.

The organisation did not have effective systems in place to monitor the quality of the service. Audits were not conducted of care records. Information was not reported to the CQC as required. We found evidence of two safeguarding incidents that were not reported in line with requirements. We saw evidence that feedback was obtained from people using the service and the results of this was positive.

We have made a recommendation about safe medicines management. We found five breaches of regulations in relation to safe care and treatment, consent, person centred care, submitting notifications to the CQC and good governance. You can see what action we told the provider to take at the back of the full version of the report.

## 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 consistently safe. People's care plans and risk assessments were sometimes inconsistent and sometimes lacked informationcontained errors which may have put people at risk of avoidable harm.

Procedures were in place to protect people from abuse. Staff knew how to identify abuse and knew the correct procedures to follow if they suspected abuse had occurred.

There were enough staff available to meet people's needs and we found that recruitment processes helped to ensure that staff were suitable to work at the service.

We saw accurate records were kept of the support people received with their medicines.

### Is the service effective?

**Requires Improvement**

The service was not always effective. The service was not always meeting the requirements of the Mental Capacity Act 2005. Care records did not always contain details of people's capacity and senior staff did not identify whether relatives had the legal authority to sign their family member's documentation. Care staff were aware of their responsibilities under the MCA 2005.

Staff received an induction, training and regular supervisions of their performance. However, appraisals were not held regularly and some staff had not had an appraisal for over two years.

Information about people's health and dietary needs within care records was incomplete.

### Is the service caring?

**Good**

The service was caring. People using the service and their relatives made positive comments about the care provided by staff.

People and their relatives told us that care workers spoke with them and got to know them well. People and their relatives

confirmed their privacy and dignity was respected and care workers gave us practical examples of how they did this.

Care workers had a good level of knowledge about people's culture and religions and how this influenced and contributed to the support they provided.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive. People's needs were assessed before they began using the service and care was planned in response to these. However, care records were not always complete and did not always contain information about people's preferences in relation to how they wanted their care to be delivered.

People were encouraged to be active and maintain their independence where this was part of the package of care required. However, care records contained very limited details about the social and leisure activities people enjoyed.

People told us they knew who to complain to and felt they would be listened to.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well-led. information was not reported to the Care Quality Commission (CQC) as required. We identified two safeguarding incidents that had not been reported to the CQC. There was evidence of medicines audits taking place, but there was no evidence of audits being conducted in relation to care records. Therefore, the shortfalls we identified in care records had not been identified or addressed.

People, their relatives and staff gave good feedback about the registered manager.

# Respect Care Services Limited

**Detailed findings**

## Background to this inspection

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

The inspection took place on 5, 6, 7 and 10 October 2016 and was conducted by two inspectors and an expert by experience who assisted us by conducting telephone interviews with people who used the service after our inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection was announced. We gave the provider 48 hours' notice of our inspection as we wanted to be sure that someone would be available.

Prior to the inspection we reviewed the information we held about the service and we contacted a representative from the local authority safeguarding team.

We spoke with 22 people using the service and five relatives of people using the service. We spoke with 13 care workers during our visit as well as the registered manager, the nominated individual, the deputy manager and other administrative staff. We also looked at a sample of 20 people's care records, 15 staff records and records related to the management of the service.

Requires Improvement

# Is the service safe?

## Our findings

People told us they felt safe when using the service. Comments from people included "I do feel safe yes, I have good carers coming to help me" and "I do feel safe, thank you, having these people helping me."

Despite these positive comments we found that the provider had not always taken sufficient action to protect people from avoidable harm.

We looked at people's support plans and risk assessments. The registered manager or another senior member of staff visited people in their homes and conducted risk assessments on the safety of the person's home environment as well as conducting a needs assessment around areas of support. This included the person's medical conditions, their personal care needs, whether they required domestic support and other areas related to the person's wellbeing. This information was then used to produce a care plan around the person's identified needs.

However, we found that some people's care plans and risk assessments were inconsistent and sometimes lacked information.. For example, in one person's care record we found inconsistent records kept with regard to whether the person smoked. We saw some written advice to care workers in how to manage the person smoking and another record which stated that they did not smoke. There was no specific risk assessment to manage the risks associated with the person's smoking and help protect the person from avoidable harm.

For another person we found their moving and handling risk assessment concluded that the person had fallen a number of times. Care workers were advised to supervise the person when mobilising. However, there was no recorded detail as to how these falls had occurred and hence what the specific risks of the person mobilising were.

We found a further record in another person's care file that indicated that they had a history of leg sores. However, it was not clear whether this remained a risk, when the person had last experienced a leg sore and whether there were any preventative actions required of care staff to minimise the possibility of this recurring. Therefore we could not be assured that risks were adequately assessed and managed to protect people from avoidable harm.

The above issues constitute a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they received training in safeguarding adults as part of their initial induction and demonstrated a good understanding of how to recognise abuse, and what to do to protect people if they suspected abuse was taking place. The provider had a safeguarding adult's policy and procedure in place and records indicated that this was being followed thereby ensuring the appropriate management and reporting of safeguarding matters. A member of the safeguarding team at the local authority confirmed they did not have any concerns about the safety of people using the service.

Staff received emergency training as part of their initial induction and this covered what to do in the event of an accident, incident or medical emergency. Care workers told us what they considered to be the biggest risks to individual people they cared for and they demonstrated an understanding of how to respond to these risks. For example, one care worker demonstrated that they understood a person's behaviour well and anticipated possible risks when they were out in the community. They explained that they managed this by remaining vigilant and closely observing the person to keep them safe. In the event of an incident, care workers told us they would contact the emergency services or take other appropriate action, which could include informing a GP and their manager.

Care workers were responsible for prompting some people to take their medicines. The registered manager or other senior staff member conducted a spot check visit to each person's home approximately every two months and checked medicine administration records (MARs), people's medicines and daily care notes on their visit. This meant that any discrepancies in recording or any errors in the administration of medicines may not have been identified or addressed for a significant period of time after the incident occurred which could have put people at risk. We recommend the provider take advice from a reputable source about appropriate monitoring checks to ensure that medicines are managed safely.

We saw a written record was kept of spot checks and comments were made about the quality of the record keeping. On the basis of these records we found the MARs were fully and accurately completed. The registered manager told us that in addition to the spot checks, she checked these records upon receipt at the office and if all was satisfactory, the records would be quickly archived. We were therefore, unable to review records for each of the care records we checked as records had usually been archived. However, we saw some MAR charts and daily notes for some of the people whose care records we reviewed and found these were fully and accurately completed.

Care workers we spoke with told us they had received medicines administration training. Care workers were clear about the medicines that people should be taking and provided appropriate support that met people's individual needs.

People using the service and their relatives told us they were usually seen by the same care workers and this ensured they could develop a relationship and get to know one another well. Comments included "There are three carers who come regularly. This ensures the care is stable and [my relative] remembers them", "We are very fortunate to have our regular carer. She is wonderful" and "I usually have the same carer. I'm very lucky to have her". People and their relatives told us and care workers confirmed they had enough time when attending to people and did not seem rushed when working.

We spoke with the registered manager about how they assessed staffing levels. They explained that the initial needs assessment was used to consider the amount of support each person required. As a result senior staff determined how many care workers were required per person and for how long. Senior staff told us they always discussed the results of their assessments to relevant parties including healthcare professionals, the person and their relatives. If as a result of their assessment more care workers were needed than requested for the person, this would be negotiated. Care workers also confirmed that they kept the office informed about whether they needed more time to conduct their work. They told us the timings of their visits could be extended if this was required.

We looked at the recruitment records for 15 staff members and saw they contained the necessary information and documentation which was required to recruit staff safely. Files contained photographic identification, evidence of criminal record checks, references including one from previous employers and application forms detailing their employment history.

Requires Improvement

# Is the service effective?

## Our findings

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA, and found that the provider was not always meeting the requirements of the Act. For example, we saw many examples of care records that were not signed by the person using the service in order to demonstrate that they had given their consent to the agreed care and support. There was also no indication within the records about whether the person had the capacity to make this decision. We saw some examples of care records being signed by the person's next of kin, but the registered manager could not provide us with evidence that they had the legal authority to do so or that the person lacked the capacity to do so for themselves.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with care workers about their understanding of the issues surrounding consent and the MCA. Care workers explained what they would do if they suspected a person lacked the capacity to make a specific decision. They described possible signs that may indicate that a person lacked the capacity to make a specific decision and told us they would report this to their manager.

People told us they were encouraged to eat a healthy and balanced diet where this was part of the package of care they received. People's care records included some information about their dietary requirements, but this information was usually very brief and there was very little recorded information on people's likes and dislikes in relation to food. Care workers told us they usually did not prepare meals for people, but usually only heated and served food. Care workers told us meals were usually prepared by family members, but if there were additional requirements for them, this would be specified prior to their attendance.

We found some examples of incomplete information within care records with regard to people's nutritional needs. For example in one person's care record we saw a note that told care workers that the person had a medical condition and they should consider this when preparing their food. However, there was no recorded detail about how this affected their diet. In another person's care record we saw a note which confirmed that they were on a particular diet, but there was no recorded detail about food they were allowed to eat. In a further care record we saw a note that stated that the person had a physical condition and care workers should consider this when assisting the person with their food. However, there was little recorded advice as to how the care should be provided. We also found notes in some people's care records which stated that they required assistance with their meal preparation. However, there was very little recorded detail about what food they liked to eat. Therefore we could not be assured that staff had all the information they

required to support people with their nutritional needs.

Care records contained some information about people's health needs but this information varied in detail. For example, in one care record we saw a note stating the person suffered from depression and that they lacked confidence. However, there was no information included to assist care workers in managing the person's depression or any information about factors that affected the person's mood. There was a note in this care record which stated that care workers were to become familiar with the triggers that affected the person's mood, but there was no recorded detail about what these were. We saw a similar note in the care record of another person suffering from depression. The note also stated that care workers were required to become familiar with the triggers that affected the person's mood, but there was no indication as to what these were. Therefore we could not be assured that staff had all the information they required to support people with their health needs.

Staff told us they felt well supported and received regular supervision of their competence to carry out their work. The registered manager told us supervisions were supposed to take place every two months, and we saw records to confirm this was taking place.

The registered manager also told us annual appraisals were supposed to be conducted of care workers performance once they had worked at the service for one year. Care workers told us and records confirmed these were taking place. Care workers told us they found these useful to their practise.

People told us staff had the appropriate skills and knowledge to meet their needs. Relatives said, "They're very good and know what they're doing" and "They want to do the job right." Senior staff told us and care workers confirmed that they completed training as part of their induction as well as regular ongoing training. Records confirmed that staff had completed mandatory training in various topics as part of their induction prior to starting work. These topics included safeguarding adults, first aid and dementia. Care workers were also able to request more specialist training depending on the needs of the people they supported. For example, we found care workers had received specific training in administering eye drops to people before doing so to ensure they had the appropriate skills to do this safely.

Good

# Is the service caring?

## Our findings

People and their relatives gave good feedback about the care workers. People told us, "They are very caring", "They are concerned about me. They are wonderful" and relatives said "I'm very, very happy with Respect Care" and "I know all their names. They're real people who are friendly and genuinely care about what they do". People told us they were treated with kindness and compassion by the care workers who supported them and said that positive relationships had developed.

Our discussions with senior staff and care workers showed they had a good knowledge and understanding of the people they were supporting. Care workers told us they usually worked with the same people so they had got to know each other well. Care workers gave details about the personal preferences of people they were supporting as well as details of their personal histories. They were well acquainted with people's habits and daily routines and the relatives we spoke with confirmed this.

People we spoke with confirmed that their privacy was respected. Comments included "They respect me" and "They're very respectful of [my relative's]. They wear shoe protectors and do little things like that which make a difference." Care workers explained how they promoted people's privacy and dignity and gave many practical examples of how they did this. Comments included, "I'm careful when I give people personal care. I make sure the curtains are closed and no one can walk in" and "I always make sure I cover the person when giving personal care so they're not exposed if they don't need to be. I also tell them what I'm going to do before I do it."

Care records gave limited details about people's cultural and religious requirements, but the registered manager confirmed that these were identified when people first started using the service and where relevant, records included this. However, in most instances we found little or no recorded details for people whose first language was not English and for people who were born and raised in another country before moving to the UK. The registered manager told us this happened in situations where people were not supported with their cultural or religious needs. However, this did not take account of the important role that a person's culture or religion may play in their lives and how care workers could contribute to this when supporting people. When we spoke with care workers they had a good level of knowledge about people's culture and religions and how this influenced and contributed to the support they provided.

Requires Improvement

# Is the service responsive?

## Our findings

People's care was not always planned in a way that took account of their individual needs and preferences. Care plans provided some information about how a person's needs and preferences should be met. However, information was not always detailed. For example, most care records contained either very limited or no information about people's life history or preferences in relation to how they wanted their care to be delivered. This meant we could not be assured that people's preferences were being met.

Care records showed limited details about people's involvement in activities where the service was providing long term care for most of the day. As part of the initial needs assessment, the registered manager or other senior staff spoke with people and their relatives about activities they were already involved in so they could continue to encourage these where they were able to do so within their visits. Senior staff told us they worked with family members to keep people active by encouraging them to participate in activities they enjoyed. However, we found care records contained very limited details about the social and leisure activities people enjoyed and whether or not these were taking place. This occurred where care workers were providing people with care for most of the day. For example, we looked at the care record for one person and noted that they received eight hours of care a day, five days a week, but their care plan did not contain any details about what they enjoyed doing during the day time.

People using the service and relatives we spoke with confirmed they had been involved in the assessment process and had regular discussions with staff about their needs. Relatives also confirmed care staff kept daily records of the care provided and these were available for them to see. We saw evidence that most people's care records were reviewed within 12 months to reflect any changes in people's needs.

People using the service and relatives we spoke with told us they were involved in decisions about the care provided and staff supported them when required. Comments included "Respect Care listen to our suggestions and act on our feedback" and "They are a very responsive service."

Care workers told us they offered people choices as a means of promoting their independence. One care worker told us "I always ask people what they want. I don't do anything for people, I involve them." We saw many written examples within care records of suggestions to care workers in how they could involve people in the care being provided in order to promote their independence. For example in one care record we saw details of how the person could assist with preparing their own meals and we saw instructions that the person was to be encouraged to use their walking aid as opposed to their wheelchair to help improve their mobility.

People's needs were assessed before they began using the service and care was planned in response to these. Assessments included physical health, dietary requirements and mobilising.

The service had a complaints policy which outlined how formal complaints were to be dealt with. People who used the service and their relatives confirmed they knew who to complain to where needed. Senior staff told us how they handled complaints and we saw records to demonstrate this. Complaints were managed in

line with the policy to people's satisfaction. We were told that where possible, improvements were made to the service as a consequence of complaints received.

Requires Improvement

# Is the service well-led?

## Our findings

People were not fully protected against the risks associated with their care and support as the provider did not always report concerns to the Care Quality Commission (CQC) as required. We identified two safeguarding incidents that had not been reported to CQC as required so that these could be assessed and action taken where appropriate.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider did not have adequate systems in place to monitor the quality of the care and support people received. We saw evidence of audits on medicines administration but did not see evidence of audits or any other monitoring of care records. This meant the provider was not assessing, monitoring or mitigating the risks we found to service users within the inconsistent or incorrect care plans and risk assessments.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw accident and incident records. There was a clear process for reporting and managing these. The registered manager told us they reviewed accidents and incidents to monitor trends or identify further action required and we saw evidence of this. There was evidence of further actions taken as a result of accidents and incidents in the form of further discussions with care workers to remind them of risks and actions that needed to be taken to mitigate risks.

We saw evidence that feedback was obtained from people using the service, their relatives and staff. Feedback was sought during monitoring visits and monitoring telephone calls which took place approximately every two months. The registered manager told us that if issues were identified, these would be dealt with individually. We saw recorded details of this monitoring within the records we viewed and found feedback to be positive. Care workers also filled in 'weekly feedback forms' in which they detailed any changes relating to the people they had cared for and these forms were reviewed by the registered manager. The registered manager told us that she took action where required to ensure that people's needs were met.

Care workers confirmed they maintained a good relationship with their manager and felt comfortable raising concerns with her. One care worker said, "She is a very nice person. I feel confident approaching her. If there are any issues, I know she will deal with it" and another said, "She takes care of all the employees, she is always available" and "She's very good. A very lovely lady." Care workers told us the registered manager worked hard to promote their wellbeing. Team meetings took place on a monthly basis and these were divided into the separate regions that care workers were based. At these meetings, care workers were asked what food they would like to have and the registered manager prepared this. One care worker told us "She cooks for us. It is very nice."

Staff demonstrated that they were aware of their roles and responsibilities in relation to people using the

service and their position within the organisation in general. They explained that their responsibilities were made clear to them when they were first employed. Staff provided us with detailed explanations about what their roles involved and what they were expected to achieve as a result. We saw copies of people's job descriptions and saw that the explanations provided reflected these.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The provider failed to notify the commission without delay about any abuse or allegation of abuse in relation to service users. (Regulation 18(1)(2)(e)). |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider did not act in accordance with the Mental Capacity Act 2005 in circumstances where service users may have lacked capacity to consent to decisions regarding their care (Regulation 11(3)). |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider did not assess the risks and do all that was reasonably practicable to mitigate against such risks in the delivery of care. 12(1)(2)(a) and (b). |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not assess, monitor and mitigate the risks relating to the health, safety and welfare of service users which arise from the carrying on of the regulated activity. |

17(1)(a).