Romie Care Services Limited

Romie Care Services Ltd

Inspection report

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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

At our last comprehensive inspection of this service in November 2017, we rated the service as 'requires improvement.' This was because we found sometimes people did not receive the care and support as planned as calls were late, early or missed. People felt this was due to staff not being available and due to shortfalls in rostering of calls, shortage and lack of appropriate deployment of staff. Management systems did not always identify the shortfalls in the planning and management of the service so that actions could be taken to rectify the issues in a timely manner.

At this inspection we found the required improvements had not been made and the service in now in breach of regulations. This is the fourth inspection where we have rated the service as requires improvement. This shows that the provider has been unable to make or sustain the improvements required.

We gave the provider 48 hours' of our intention to undertake the inspection. This was because the service provides domiciliary care to people in their own homes and we needed to make sure someone would be available at the office.

Romie care (which runs as a franchised branch of Surecare) is registered to provide personal care to people living in their own homes. On the day of our inspection the service was provide personal care to 100 people. A registered manager was in place. A 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.

People told us that staff frequently arrived late for calls. People were reliant on staff and late calls had a negative impact on them. People told us late calls left them waiting for personal care and support with meals and medicines.

The provider had a call monitoring system in place, however, records showed that calls were being scheduled later the agreement times.

Staff understood how to protect people from abuse and were clear about the steps they would need to take if they suspected someone was unsafe.

People told us they received their medicines as required and staff said they had received medication training to support people appropriately.

The provider completed employment checks to ensure staff were suitable to deliver care and support before they started work. They need to strengthen the process further and ensure a full employment history was completed for all staff.

People told us staff knew them well and had the skills and knowledge to meet their needs; Staff told us they received the right training for the people they supported.

People said staff supported them by preparing a choice of meals and drinks to support their wellbeing. Staff understood they could only care for and support people who consented to being cared for.

People said staff were caring and treated them with privacy and dignity and respected their homes and belongings.

People told us when they raised concerns these were not always listened to or action taken to resolve them. The provider had not logged concerns of late calls as complaints therefore learning had not been taken to minimise the chance of things going wrong again in the future.

People said the management of the service needed improving to ensure calls were made on time to meet their needs and concerns were responded to.

The provider did not have effective systems in place to check and improve the quality of the service. The provider confirmed that prior to the inspection they were not auditing call times to assess if calls were on time and take appropriate action where required. The provider said audits checks that people were receiving medication as required were completed, but these were not available to the inspector on the day of the inspection, therefore we could not be assured these checks were in place.

You can see what actions we told the provider to take at the back of the full version of this 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 remains as requires improvement.

Care calls to people were frequently late. Some people told us they had been left waiting for staff to arrive and this had a negative impact on them.

People received care from staff that understood how to keep them safe and minimise the risk of potential harm.

The provider completed employment checks to ensure staff were suitable to deliver care and support before they started work. They need to strengthen the process further and ensure a full employment history was completed for all staff.

People told us they received their medicines as required and staff said they had received medication training to support people appropriately.

Is the service effective?

Good

The service remained Good.

Is the service caring?

Good

The service remained Good.

Is the service responsive?

Requires Improvement

The service has deteriorated to requires improvement.

People told us they had raised concerns but felt these were not listened to and action was not taken to resolve them.

People told us communication from the provider needed to improve so they received information when calls were running late.

Staff provided care that took account of people's individual needs and preferences and offered people choices.

Is the service well-led?

Requires Improvement

The service remains as requires improvement.

This is the fourth inspection where we have rated this question as requires improvement. This shows that the provider has been unable to make or sustain the improvements required.

People said the management of the service needed improving to ensure calls were made on time to meet their needs.

The provider did not have effective systems in place to check and improve the quality of the service. Audits need to be developed to ensure that checks are made and actions action taken where required to improve standards of people's care.

Romie Care Services Ltd

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 inspection took place on 11 and 16 October 2018 and was announced. The provider was given 48 hours' notice because the location provided a domiciliary care service. The provider can often be out of the office supporting staff and we needed to ensure that someone would be in. The inspection team consisted of one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, with an area of expertise in dementia care.

As part of the inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law. We asked the local authority if they had any information to share with us about the service. The local authority is responsible for monitoring the quality and for funding some of the people receiving care support.

During the inspection we spoke with 12 people who received care by telephone. We also spoke with three relatives of people who received care. We spoke with the provider, the registered manager, the systems administrator, one care co-ordinator, one senior carer and nine care assistants. Romie Care is run as franchised branch of Surecare and we also spoke to the business development manager from Surecare. We looked at care plans for eight people, three staff recruitment files, complaints and compliments records, safeguarding incident records and the provider service questionnaire.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in November 2017, we rated this key question as 'Requires Improvement.' This was because sometimes people did not receive the care and support as planned as calls were late, early or missed. People felt this was due to staff not being available and due to shortfalls in rostering of calls, shortage and lack of appropriate deployment of staff. At this inspection we found the required improvements had not been made and the rating remains unchanged and the provider is now in breach of regulations.

People told us staff were frequently late in attending calls to support them. One person said, "Sometimes they are over two hours late and I'm left on my own waiting to go to bed. I'm not safe to go myself so I have to just wait for them to turn up." A second person told us they had an early morning call, however, "It can be late morning, it can be almost lunch time." They added that due to an ongoing healthcare condition, "[The] haywire timing is a worry to me." A third person told us, they had an evening call for staff to prepare their evening meal. They said the call was often late, stating the call time was, "Different all the time." They added, "I can be hungry if they are late."

We spoke with 12 people and three relatives about the care provided and five people and one relative raised concerns to us about late calls. One person told us because, "They kept being very late," they had given notice to move to another agency. They concluded, "In the end, I can't keep having a half-hearted service."

Three people and two relatives we spoke with also commented about short calls, with staff not staying for the full allocated time. One person said, "Sometimes they [staff] slip away early. They go as soon as their transport comes and sits outside, that's when they start to finish no matter what time it is." They added that, "The tension when the transport arrives outside is felt throughout my home." A second person commented, "They never stay and talk when they're done with their tasks, yet [they] have…. time left." One relative also commented, "They [provider] could do with a bit more monitoring their carers; make sure they stay the full time but they are short staffed and rushed."

Some staff we spoke with told us that the scheduling of calls was ineffective and more staff were needed. One member of staff said, "Calls are done in the wrong order. One person is down for a call 50 minutes later than their agreed time. I know if I go at that time they will be upset so I change the calls around myself. The office sometimes rota calls for times I can't even make and I've told them that." Another member of staff said, "We definitely need more staff to cover all the calls."

We looked at the on-call log which was a record of telephone calls taken from people. We saw frequent calls from people receiving care stating they were waiting for their carer to arrive and raising concerns about late calls. We looked at call times for calls made in September for six people and five of these showed that calls were being scheduled and made later than agreed time.

The provider and registered manager told us that a call monitoring system had introduced in May 2018, which required staff to log in into the system at the start and end of each call so call times could be

monitored but this had not been consistently used by all staff. They acknowledged the incorrect scheduling of calls identified in the inspection. We raised our concerns with the local authority safeguarding team for them to consider.

Romie Care is run as franchised branch of Surecare. Immediately following the first day of the inspection action was taken; a representative from Surecare worked with the management team of Romie Care and all rotas were reallocated based on the agreed call times. Call monitoring reports had also been completed which showed the number of late calls over the previous two months. An action plan was put in place to ensure monitoring reports were completed and actions taken in a timely way going forward.

The providers systems had not been effective in providing safe care and treatment. We consider this is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with confirmed that they had received training in safeguarding people and demonstrated a good understanding of the types of abuse people could be at risk from. Staff were clear about the steps they would take if they had any concerns. Staff told us they were confident to report any concerns with people's safety or welfare to the provider and felt that action would be taken.

Staff we spoke with were able to describe the different risks to people and how they supported them. For example, when people would need the support of two carers. Staff told us people's risks had been assessed when they first received care from the service and had then been reviewed regularly and changes recorded in their care plans. Staff said the assessments gave them the correct level of information to provide care and support and were kept up-to-date to ensure they were aware of any changes to people's care needs.

We saw records of employment checks for three staff completed by the provider to ensure staff were suitable to deliver care and support before they started work. One member of staff also confirmed the checks made and told us, "They [the provider] did checks, like references and the DBS before I could start." Whilst the provider had made reference checks with previous employers and with the Disclosure and Barring Service (DBS); they need to strengthen the process further and ensure a full employment history was completed for all staff.

Five people we spoke with told us they received support with their medicines. One person said, "They [staff] put the tablets in my hand, they see that I take them." They added that staff checked the records to ensure that they had taken their tablets with the previous member of staff. Two people raised concerns that late calls could sometimes impact on the time they took their medication. Staff told us they completed medication training before supporting people.

All of the people we spoke with said although staff wore uniforms and protective gloves when providing care, staff did not wear aprons. One person "I'm concerned about infection and what is on their clothes." Another person said, "I've never seen them with aprons." All staff said gloves and aprons were supplied by the provider and were used. We also saw the provider also did spot checks which included a check of uniforms. We spoke to the provider and registered manager about this issue, they advised this would be addressed with staff immediately following the inspection.

Good

Is the service effective?

Our findings

At the last inspection in November 2017, we rated this key question as 'Good.' At this inspection the rating remains unchanged.

People told us staff had the required skills to support them. One person commented they felt staff had the right skills to support them with their health condition. They said, "They [staff] all seem to know how to support me." Adding, "I feel sure they do have the right skills." One relative commented, "They seem confident in what they're doing."

Staff we spoke with told us that training helped them to do their job and that they were happy with the amount of training they had received. Staff gave examples of where training had improved the care they provided to people. For example, one staff member told us how manual handling training had improved their confidence in supporting people. New staff told us induction training was good and it included shadowing experienced staff. This was confirmed by people we spoke with. One person said, "I've never had a new one [member of staff] come without an experienced carer."

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The 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. Any applications to deprive someone of their liberty for this service must be made through the Court of Protection.

Staff we spoke with told us they had completed MCA training and were aware of their responsibilities to ensure people's consent to care and treatment was sought and recorded. This was confirmed by people we spoke with. One person told us, "I'm involved, I make my own decisions." We saw people had signed agreement of their care plans.

Some people were being supported by staff to eat and drink enough to keep them well. People told us staff ensured they had a choice of what they would like to eat and staff left a drink to hand at the end of a call. One person said, "They [staff] always say, 'What would you like today?' I tell them what I fancy, and we then decide. They make me a cup of tea to go with it." Another person said, "They cook what I ask them to. They do it just how I want and give me a cup of tea with it." We saw one person had requested staff able to prepare meals reflecting their cultural heritage and this had been supported by the provider.

People told us staff would support them access medical care if needed. One person told us staff had supported them when they were unwell. They said, "I had a bit of a temperature, so [member of staff]

organised it all, got in touch [relative's name] and a doctor's appointment was organised." Another person commented, "[Staff] are pretty good, if they see anything they do say you should call the doctor, they notice things." Three people told us although family arranged their healthcare appointments they were assured staff would help them if needed. One person said, "I'm sure they would help if I asked though."

Good

Is the service caring?

Our findings

At the last inspection in November 2017, we rated this key question as 'Good.' At this inspection the rating remains unchanged.

People spoke positively about the individual staff that supported them. One person commented, "My carers [staff] are lovely, they look after me well." Another person said, "They're lovely, they talk to me about all sorts, they can't do enough."

People felt staff were caring. One person told us staff always did little extras. They said, "Before they go they make a lovely cup of tea, just the way I like it." Another person told us how staff changed the way they cared for them in response to how they were feeling. They said, "They give me a bed wash when I'm really struggling. it's brilliant because I still get a wash when I'm not feeling good and [they] get my cats in before they leave, they know I'll worry otherwise."

People said staff supported them with dignity and respect. One person said they felt respected because, "They [staff] like to chat to me." Two people said they felt assured that staff respected their home and belongings too.

People told us they had developed good relationships with their regular staff. One person commented, "They're marvellous, they treat me like I'm their family." Another person commented they felt comfortable with staff because, "I've known them for years." One relative also commented, "[Family member's name] thinks they're their best friends and is comfortable with them." Staff knew how to provide care in the way people wanted. One person said, "They do exactly what I want."

Staff we spoke with said they enjoyed working with people and had developed good relationships. One member of staff told us, "I love working with my clients [people receiving care]. It doesn't feel like work."

Staff we spoke with also shared their understanding of caring for someone with dignity. They told us about practical ways in which they maintained a person's dignity. One staff member listed things they did such as closing curtains when people were getting dressed as well as ensuring doors were closed when supporting people with personal care and ensuring personal information was confidentially maintained.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in November 2017, we rated this key question as 'Good.' At this inspection we found the service had deteriorated and we now rate this key question as 'requires improvement.'

People told us that if they had a concern, such as a late call, as directed they would ring the office using the on-call telephone number. However, some people told us they did not feel that their concerns were always listened to or resolved. One person said, "I've given up, there's no point anymore, nothing changes." A second person commented, "They're [management team] good at saying they apologise, the challenge is making the changes." They added they didn't feel the necessary changes had been made despite raising concerns of late calls on several occasions. One relative also commented, "[Relative's name] has raised several concerns regarding the timekeeping. It hasn't changed, I don't think they do listen."

Two people also told us where they had raised concerns and requested a change in the staff supporting them, although initially changes had been made, on occasion the same staff had returned. One person said, "I've told them time and time again." Three staff told us they were aware that people they provided care to had called in to complain about late calls. One member of staff said, "I think they just give up, some have told me they will give notice and will go to another agency."

The provider told us only one written complaint had been received in the past 12 months; the complaint concerned late calls and lack of communication. We saw that following receipt of the complaint, the provider had held meeting with the person involved and a subsequent staff meeting had discussed the need to ensure staff communication. We checked call times for September 2018 and the records showed that the person continued to receive late calls.

We saw the provider had sent a questionnaire to people using the service in August 2018 asking for feedback on the service provided. Results showed that 30% of people said they were unaware of how to make a complaint. The provider advised in response to the questionnaire a new pictorial guide on their complaints procedure had been developed and would now be sent to all people using the service.

The provider had failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. We consider this is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were involved in planning their care when they first received support but gave us mixed responses about whether they were involved in the continued planning and reviews of their care. One person said, "Someone came here [when I first received care], we talked about everything I was needing, nobody has been out to do that since then." We saw records of reviews including examples where some people had raised concerns about late calls. We saw the provider had noted an action of looking into these issues, however we could not see where the issues had been resolved.

People told us communication from the provider needed to improve. Five people we spoke with told us they did not receive communication when calls were running late. One person said, "No, [they] never call." Two other people told us communication was inconsistent. One person said, "Sometimes they do, sometimes they don't," regarding being notified when calls were running late. Results from the providers questionnaire showed that more than 30% of people who responded felt they were not adequate informed of changes by the provider. A report by the provider on the outcome of the questionnaire said, 'communication must be improved upon.' The provider told us in response they had plans to reintroduce a newsletter and were in the process of considering other actions.

Three staff also told us that communication could be improved. One member of staff said, "Office communication with the service users [people] is not quite there. I feel sorry for people, they should get a call." Another member of staff said, "I'd rate the communication as 'zero'."

We asked the provider about this they told us on-call logs should record the date and time of the when telephone calls were made, however we saw that frequently the time of the calls to people were not recorded therefore, we were not able to see when the calls had been made.

Where people had regular staff supporting them they told us staff knew them well and provided care in the way they wanted. One person said, "[Staff] know exactly how I like everything done." One relative also commented, "They know how [family member's name] likes to be washed, in what order they like it done.'

Care files contained information about people's personal histories and people's preferences, so staff could consider people's individual needs when delivering their care. We saw the provider had provided staff with appropriate language skills and also provided staff at the person's request to support the preparation meals reflecting one person's cultural heritage.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in November 2017, we rated this key question as 'Requires Improvement.' This was because management systems did not always identify the shortfalls in the planning and management of the service so that actions could be taken to rectify the issues in a timely manner. At this inspection we found the required improvements had not been made and the rating remains unchanged and the provider is now in breach of regulations. This is the fourth inspection where we have rated this question as requires improvement. This shows that the provider has been unable to make or sustain the improvements required.

People told us they felt the management of the service needed to improve. One person commented, "They [staff] try hard to meet your needs but the management need to improve." Another person said, "I wouldn't recommend them because I wouldn't want anyone else to put up with the things I have put up with [referring to their concerns]. They need to sort themselves out."

We looked at the governance systems used by the provider because we wanted to see how regular checks and audits led to improvements in the service. The provider acknowledged that management reports to analyse call times and call lengths had not been completed to identify where improvements were needed and to take action where required. During the inspection we identified that calls for some people had consistently been scheduled later than the agreed time. We asked the registered manager and provider about this. They advised they were not aware of this issue prior to the inspection and the scheduling of calls had not been overseen or checked by the management team.

Although people told us they received support with their medications as required, the provider was not able to show us any audits completed to monitor this. The provider told us audits were completed but the system used had changed following the introduction of a new care recording system. We were advised previous audits were held on computer but the provider was unable to access these records during our inspection.

The provider did show us one medication administration record (MAR). The record showed the medication for one person over a one month period. The record had gaps where no recording had been made and the daily administration of eye drops each evening had not been recorded on the form at all. From the MAR record and in the absence of completed audits we could not be assured that people had received their medication as prescribed.

The providers systems had not been effective at improving the quality of the service and the service had failed to achieve and sustain a minimum overall rating of 'Good' at four consecutive inspections. We consider this is a breach of regulation 17 'Good governance' of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff gave us mixed feedback about staff communication and whether they received regular supervision and attended team meetings. Three staff told us staff meetings should be held more often to address concerns and four staff told us that communication between office staff and staff providing calls needed to improve.

We looked at the minutes for three staff meetings, these showed only a limited number of staff attended. We asked the registered manager about this, they told us where staff were unable to attend minutes of the meetings would be sent out via email, however the some staff we asked about this said they did not receive the minutes.

The registered manager said they felt supported by the provider. They said the provider worked at the office each week so they were on-site and available to them. They told us they kept their knowledge up-to-date by accessing information and updates from the CQC website and Surecare guidance and information.

Records we saw showed the management team worked with other agencies to support the well-being of the people. For example, we saw contact made with social workers and community health teams. The provider also attended provider meetings arranged by the local authority.

The provider said they accepted the issues identified in the inspection. They advised action had already been taken to correct the times that calls were scheduled. They said, "We are a work in progress, we aim to improve. I can assure you that changes will be made." They showed us that an action plan was in place and the decision had also been made to not take on any new packages of care until the scheduling issues had been fully addressed and additional staff had been recruited.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The providers systems had not been effective in providing safe care and treatment.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers systems had not been effective at improving the quality of the service and the service had failed to achieve and sustain a minimum overall rating of 'Good' at four consecutive inspections.

The enforcement action we took:

We have issued a warning notice