

Roses Healthcare Ltd

Roses Healthcare

Inspection report

67 Lorraine Crescent
Northampton
Northamptonshire
NN3 6HW

Tel: 07934532741

Date of inspection visit:
31 January 2019
06 February 2019

Date of publication:
05 April 2019

Ratings

Overall rating for this service	Inspected but not rated
Is the service safe?	Inspected but not rated
Is the service effective?	Inspected but not rated
Is the service caring?	Inspected but not rated
Is the service responsive?	Inspected but not rated
Is the service well-led?	Inspected but not rated

Summary of findings

Overall summary

This inspection took place on 31 January 2019 and 6 February 2019 and was the first inspection since the service was registered with the CQC in December 2017.

Roses Healthcare is a domiciliary care agency. It provides personal care to children, younger adults and older people living in their own houses and flats in the community. Not everyone using this service receives the regulated activity; The Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

On this inspection we were unable to provide the service with a rating. This is because the service had not been providing care and support to enough people over a long enough time period for us to review.

The service had a registered manager. 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.

People received care from the provider who was kind, caring and passionate about providing the care and support people required.

The provider and the registered manager had the skills and knowledge to provide the care and support to the person using the service.

People had care plans that were personalised to their individual needs and wishes. Records contained detailed information to assist staff to provide care and support in an individualised manner that respected each person's individual requirements and promoted treating people with dignity.

People's health and well-being was monitored and they were supported to access health professionals in a timely manner when they needed to. People were supported with their dietary requirements and experienced caring relationships with staff. The provider and registered manager had appropriate medication training and administered medicines in accordance with their policies and procedures.

The provider and registered manager understood their responsibilities to safeguard people and knew how to respond if they had any concerns. Care plans contained risk assessments which gave instructions to staff how to mitigate risks; these enabled and empowered people to live as independent a life as possible safely.

The provider and registered manager were the only people working at the service and all support was provided by them. The provider had safe recruitment procedures in place, however because no other staff were employed we were unable to make a judgement on the safe recruitment of staff.

The provider and registered manager knew their responsibilities as defined by the Mental Capacity Act 2005 (MCA) 2005. The provider was aware of how to make referrals to the Court of Protection if people lacked capacity to consent to aspects of their care and support and were being deprived of their liberty.

The provider had systems in place to measure the quality of the service provided. However, because only one person used the service we were unable to make a judgement the effectiveness of the systems in place.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Details are in our findings below.

Inspected but not rated

Is the service effective?

Details are in our findings below.

Inspected but not rated

Is the service caring?

Details are in our findings below.

Inspected but not rated

Is the service responsive?

Details are in our findings below.

Inspected but not rated

Is the service well-led?

Details are in our findings below.

Inspected but not rated

Roses Healthcare

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.

We gave the service 48 hours' notice of the inspection visit because it is a small domiciliary care service and the provider and registered manager is often out of the office providing care. We needed to be sure that they would be in. At the time the inspection started, the service was supporting one child with their personal care needs.

The inspection was completed by one inspector. The inspection site visit activity started on 31 January 2019 and ended on 6 February 2019. It included telephone calls to health professionals. We visited the office location on 31 January 2019 to see the provider and registered manager and to review care records and policies and procedures.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made judgements in this report.

We reviewed the information we held about the service. We also contacted health and social care commissioners who place and monitor the care of people using care services and the local authority safeguarding team.

During our inspection, we were unable to speak with the person [child] who was receiving personal care services due to their communication difficulties and we were unable to make contact with the child's relative. We spoke with the provider and registered manager.

We reviewed the care records for one person who used the service. We also looked at other information related to the running of and the quality of the service. This included systems in place to monitor the quality of the service. For example; quality assurance processes, training information and arrangements for managing complaints.

Our findings

We were unable to rate the agency as there was not sufficient information available to us to fully assess how safe this service was. This was because only one person received a service and only two staff, including the provider and registered manager, were employed. The health professional we spoke with did not raise any concerns about the safety of the service provided.

Safeguarding systems were in place and the provider and registered manager knew how to report any concerns to the local authority.

The provider could demonstrate that appropriate arrangements were in place to recruit additional staff. These procedures, including obtaining Disclosure and Barring Service checks (DBS) and taking up personal references, ensured that new staff would be suitable to work with vulnerable people. The provider said, "Applicants will not be offered the job until all the necessary checks have been completed."

We saw that appropriate assessments of risk had taken place within the care planning of the person using the service. We saw that risk assessments identified the person's ability, the support required, and the risk control measures. Assessments focussed on the person's ability, healthcare needs and the importance of working closely with the family and health professionals.

There were only sufficient staff to meet the needs of one person. The provider said they were actively seeking to begin providing personal care to more people, and that more staff would be recruited to meet these needs as and when the service grew. At the time of the inspection we were unable to assess the effectiveness of this in the longer term as there was only one person currently using the service.

The provider understood the requirement to manage people's medicines safely. The provider had undertaken training in administering medicines and felt they were competent in the role. The provider and registered manager followed infection control practices, for example, when providing personal care. They told us they always had access to personal protective equipment such as gloves and aprons, to ensure that infection control was managed appropriately.

The registered manager recognised that the service was in its infancy and was committed to learning how it could continually improve. We saw that the provider had good communication with the person's relative and health professionals to ensure that the person received safe care and treatment. The provider told us they were committed to learning from any incidents, but as the service was in its infancy there hadn't been

any at the time of the inspection.

Our findings

We were unable to rate the agency as there was insufficient information available to us to fully assess how effective this service was. This was because only one person received a service and only the provider and registered manager were employed.

At the time of the inspection we were unable to fully assess the effectiveness of the training, and the monitoring of the training, as the service had only been providing personal care to one person for a short period. However, the provider had received condition specific training in PEG feeding to enable them to support the child they were caring for. (A PEG (Percutaneous Endoscopic Gastrostomy) is a way of introducing food, fluids and medicines directly into the stomach by passing a thin tube through the skin and into the stomach).

The provider and registered manager had sufficient previous experience and training in care to enable them to provide the person with the support they needed. We were assured by the registered manager that all new staff would complete mandatory training on subjects such as safeguarding, health and safety and moving and handling. Staff would then spend time shadowing the provider and registered manager to get to know how best to support a person. New staff would be signed up to the care certificate, if they did not already have a similar qualification. The Care Certificate is based on 15 standards and aims to give employers and people who receive care the confidence that workers have the skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support.

The registered manager said that all new staff could expect to be supervised on a regular basis and there was a procedure in place for annual appraisals to be undertaken.

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 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Applications to deprive a person of their liberty in their own home must be made to the Court of Protection. The provider understood the requirements of the Act but at the time of the inspection did not support any adults with the regulated activity of personal care.

At the time of inspection, the service was supporting a child with nutritional needs through a PEG. The

provider has clear guidelines of the feeding regime and knew who to contact if they had any queries or concerns about the process. People's care plans were detailed about the support the person received.

At the time of the inspection all other healthcare needs were met by the relatives of the child receiving care. However, the provider had clear guidelines in place about supporting people with health appointments when they were able to support more people.

The provider had a good knowledge about the involvement of other professionals involved in the care of the person using the service, and liaised with them where appropriate. For example, the provider liaised with social workers, the person's school, district nurses and other healthcare professionals.

Our findings

We were unable to fully assess how caring the service was as there was a very limited service being provided to one person (Child) at time of the inspection. The health professional we spoke with did not raise any concerns about the agency.

It was evident from talking with the provider and the registered manager that they were passionate about providing good quality care. We saw evidence of how the provider had been flexible in adapting the hours of care provided to meet the needs of the child and the family. The provider attended meetings with health care professionals to discuss the care they provided.

We were unable to gain feedback from the person (Child) or their relative.

The provider confirmed that people and their relatives would be involved in reviews of their care. There had not been any reviews at the time of the inspection because the person had not been receiving support for long.

The provider and registered manager told us they treated people with dignity. For example, whilst supporting people with a body wash they ensured people's bodies were kept covered up with a towel, to help respect their privacy. In addition, arrangements had been made to ensure people had privacy whilst receiving support with their personal care if other family members or visitors were present.

The provider was keen to provide additional support when people were struggling or had times of need. For example, following a hospital admission the provider extended the support hours to provide cover at the hospital to enable the family to take a break.

People's information was stored securely at the office and the provider and registered manager understood the importance of confidentiality and privacy.

The provider and registered manager had a good understanding of advocacy services and how this could be used for significant decisions, or if people required independent support to make decisions about their care. An advocate is a trained professional who supports, enables and empowers people to speak up. At the time of inspection, nobody required the use of an independent advocate.

Our findings

We were unable to fully assess how responsive the service was in the longer term as there the service was only providing care to one person at the time of the inspection.

People had care plans in place which reflected their care needs. The care plans provided guidance to staff about how people liked their care. Care plans contained information about people's preferences, for example, if they had a preference of a favourite book or television program they liked to watch. We found that the care plan was tailored to reflect the person's needs and it was clear that excellent communication with the family and other health professionals was critical to the role. The care plan contained detailed information from the person's relative about how they expressed discomfort and happiness.

The provider was committed to reviewing and updating people's care plans at regular intervals, or when their care needs changed. At the time of inspection, nobody had been using the service for longer than six months and the care plans had not required an update.

The provider and registered manager understood the person's communication needs and whilst supporting the person, used communication methods that the person used at home and school. The provider was aware that if they supported adults with personal care support in the future they were required to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016. It makes it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given.

The registered manager had a complaints procedure in place. If people expressed concerns about the service they were asked if they wished to make a complaint. The registered manager was keen to obtain feedback from people and reflect on where improvements could be made. At the time of the inspection no complaints had been made.

The service did not currently provide end of life care.

Our findings

It was clear through reading various communication the provider and registered manager provided a stable service to the person who used the service and to the relatives. We saw the relative was complimentary about the provider and the support they had provided.

The provider confirmed they regularly completed care records for people and provided other health professionals with appropriate updates as required. The provider told us when more staff were recruited they wanted the culture to be open and transparent and this approach would help to keep open communication with the management.

The provider recognised that quality assurance procedures were required and that spot checks, electronic monitoring, feedback forms, visits to people using the service and reviews of care plans and daily records would be used to review the quality of the service. However, at the time of the inspection there was insufficient information for the provider to review.

The provider understood the requirement to display their CQC ratings in a prominent place following an inspection, and to clearly display this on any website they may operate. The provider was aware of the requirement to send notifications to the Care Quality Commission (CQC). A notification is information about important events that the service is required to send us by law in a timely way. No notifiable incidents had occurred since the service had begun providing personal care.

There were policies and procedures in place which covered all aspects relevant to operating a personal care service which included management of medicine, whistleblowing and recruitment procedures. New staff would have access to the policies and procedures whenever they were required and would be expected to read and understand them as part of their role. At the time of the inspection we were unable to assess fully the effectiveness of the policies and procedures in place due to the limited service being provided and given that there were only two staff that included the provider and the registered manager.

The service worked positively with external agencies. For example, meetings had taken place with health and social care professionals and commissioners who funded the service.