Britten Associates Limited

Rivendell Care & Support

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 25 May and 03 June of 2016.

Rivendell Care and Support is a domiciliary care agency. At the time of our inspection they were registered to provide personal care to people who had a range of diagnoses. This included older people, people with dementia, learning disabilities or autistic spectrum disorder, mental health, physical disability, sensory impairment and younger adults. There were 36 people using the service.

There was 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 told us they felt safe using the service and spoke positively about staff caring for them. The registered manager had assessed the risks to people prior to offering them a service to ensure their safety.

Medicines administration records (MAR) we looked at were completed with no gaps or errors. The service audited the (MAR) to ensure safe administration of medicines.

The service had systems in place for the safe recruitment of staff.

Staff had received infection control training and they used protective disposable equipment when supporting people to avoid cross infection.

Staff had received a comprehensive thorough induction and training. However staff had not received supervision on a regular basis to support them to undertake their role. In addition there were no staff meetings to provide a forum to discuss staff concerns and share good practice.

Staff could tell us in detail about people's health support needs and were familiar with people's diversity support needs and assisted people to meet their needs.

Staff were aware of the Mental Capacity Act (2005) and asked people's consent before offering care and support.

People had care plans and the care provided was person centred and they and/or their relatives were involved in their care planning.

Staff were respectful of the people they supported and maintained their dignity.

The service had systems in place for recording and addressing complaints appropriately.

Management were accessible and responsive to people who used the service and their relatives.

The service recognised and valued excellent work by their staff and offered a reward to staff in recognition of excellent work.

The service carried out audits to ensure they were offering a high quality service but had not undertaken regular spot checks; however they had identified this as a concern and had started a recruitment process to employ another manager who would undertake this role.

We found a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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?

Good

The service was safe. Staff understood their responsibility to report suspected abuse and the service had systems in place to protect people from hazards and abuse.

There were systems in place for the safe administration of medicines.

The provider had systems in place for the safe recruitment of staff.

Is the service effective?

Requires Improvement

The service was not always effective. Staff did not receive regular supervision to support them to effectively undertake their role.

Staff could demonstrate an understanding of the Mental Capacity Act 2005, and asked people for their consent before offering care and support.

Staff completed a thorough induction and received relevant training.

People's health care and nutritional needs were met by the service.

Is the service caring?

Good

The service was caring. Staff were kind and professional in their approach to people.

Staff treated people with dignity and respect, and maintained their privacy.

People's identified diversity needs were supported by staff.

The service involved people and their relatives in care planning.

Is the service responsive?

Good

The service was responsive. People had person-centred plans

that were reviewed and updated on a regular basis.

The service had systems in place to record and address complaints appropriately.

Is the service well-led?

Good

The service was well-led. There was a registered manager in post who understood their role.

Management monitored the quality of the service provided.

The service had built positive relationships with people and their relatives.

Rivendell Care & Support

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 25 May and 03 June 2016 and was announced. We gave 48 hours' notice to be sure that the registered manager would be in the office to talk with and people's documents that might usually be kept in their homes would be available for us to look at.

The inspection team consisted of one adult social care 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.

Prior to our inspection, we reviewed information we held about the service, including notifications sent to us at the Care Quality Commission (CQC). Notifications are submissions of information to the CQC by the registered providers about certain changes, events or incidents that occur within the service. The provider had completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with eight people using the service via telephone calls and met with two people who invited us into their homes to talk with them. We talked at length with the registered manager and the co-ordinator and interviewed two staff. We looked at six people's care records this included people's support plans and risk assessments and four people's medicine administration records. We also looked at staff personnel files for four staff members, this included recruitment, supervision and training documents.

Good

Is the service safe?

Our findings

People told us they felt safe with the Rivendell Care and Support staff, "oh yes I feel safe, they are reliable and pleasant, the firm was recommended to me by my sister" and "yes I feel safe. The company was recommended to me and it's good."

The service had provided users of the service with a handbook that included advice as to who to contact if they were worried about a safeguarding issue. The staff had received safeguarding adults training and told us how they would recognise and report any signs of abuse. Staff told us that they would whistle blow if they thought the provider was not reporting safeguarding adult concerns appropriately. There were up to date safeguarding adults and whistleblowing policies available for staff. There were notices in the office about who staff could contact to report concerns. We saw that possible safeguarding concerns had been reported to the appropriate authorities and the registered manager had undertaken a detailed investigation to support the local authorities safeguarding adults enquiries. The service had systems in place to recognise and report safeguarding adult concerns.

People had risk assessments in their care records to identify and manage any risks that might cause them or others harm. The care records were being changed from an old format to a new format we looked at both types of records. We found risk assessments included pressure ulcers prevention, moving and handling, medication and mental ability. People with live in staff had personal evacuation plans in the event there was a fire in their property, these specified an escape route. The new risk assessments were colour coded to high light medium and high risk clearly to staff and there was a risk assessment overview for staff quick reference. The old risk assessments were not as easy for staff to read quickly but were still relevant and thorough.

We looked at the rotas for staff and checked them against the hours people were assessed as requiring. We found there was a clear system to identify the staff required and both staff and people using the service were given a rota in advance that showed which staff would be supporting which person at a specific day and time. The registered manager explained they provided both live in staff to people who required 24 hour support and staff who attended for a specific day and time. The service also provided two carers when a person required two to one support for example with moving and handling. The co-ordinator explained staff are allotted paid travel time to ensure the call times are realistic and manageable. They had no missed call complaints but said on a few occasions staff might be later than anticipated due to traffic delays. In this event the staff rang the office and then the co-ordinator phoned the person to let them know there was a minor delay and when to expect the staff. To ensure two staff attending one call worked well together they had a buddy system and the two staff exchanged phone numbers so they could check the other person was not running late. The co-ordinator explained they asked staff when they employed them what their availability would be and if they would be willing to be available in emergency. The co-ordinator could call on some staff at short notice if necessary if another staff member phoned in unwell.

Staff who applied to work for Rivendell Care and Support completed job application forms and had an interview to assess their suitability for the role. We saw that DBS checks were undertaken to ensure staff were safe to work with people. The provider also asked for proof of identity and address and two references

were always asked for, one of which was from the previous employer. We noted that on one record the references were stated as from the previous employer but were not stamped or on headed paper so could not be verified as authentic. We discussed this with the registered manager and explained that it is good practice to ask for the reference from the service manager or Human Resources department. The registered manager agreed they would ensure this is requested in future.

One person told us "I am happy with the support with my medicine; they make sure I take it while they are here" and "I have a blister pack, they count out my medicines from the pack and hand the tablets to me for me to take. So far so good." Most people using the service did not require support to administer their medicines this was because they either had the capacity to do this for themselves or a family member undertook this responsibility. We checked people's medicine administration records (MAR) who did require support from staff and found these to be completed with no gaps or errors. MARs were returned to the office and audited by the registered manager on a monthly basis. Staff administering medicines had received 'safe use of medicines' training. Arrangements for the delivery of medicines was specific to the individuals and agreed with their families. Medicines were described in people's care plans and reviewed to reflect any changes. There was a description of most of the medicines and their use for staff reference. Where people required controlled drugs these were administered by the district nursing service who staff liaised with when necessary. There was PRN, medicines, that is, 'as and when medicines' guidance. People had signed a consent form to say they consented to the administration of both prescribed and homely (non- prescribed) medicines We noted one person's MAR was handwritten by the senior staff member rather than typed by the pharmacist we suggested that this system is reviewed to avoid potential errors being made.

Staff had received during their induction infection control training and had signed a consent form to say that they agreed to wear protective disposable gloves when offering personal care. Staff wore uniforms to protect both people and themselves from cross infection. Staff also received food hygiene training to enable them to be aware of hazards when handling food for people in their homes.

Requires Improvement

Is the service effective?

Our findings

People told us "They are very good, the training is fine, and my carers have got to know me well. They know my moods." Staff told us "because of my training I feel confident in my skills." We saw that there was comprehensive training available for staff. There was a training room available in the offices that had space for both written and practical training sessions such as moving and handling. Staff undertook a four day induction that covered core subjects such as fire safety, safeguarding adults, moving and handling, basic life support, report writing and communication. In addition the induction looked at the code of practice for staff and gave staff 'the home workers handbook.' The registered manager explained they aimed to make the induction interesting and interactive. Explaining they are developing further training and showed us the rough draft for planned dementia training. Staff were encouraged to undertake NVQ level 2 and NVQ level 3 in health and social care. During our visit we met staff who had come into the office to attend a NVQ training session with an outside facilitator.

We looked at staff supervision records and found that some supervision had been taking place in 2016 but some staff had only received one supervision and none had taken place in 2015. The supervision policy stated staff should be supervised every three months. We brought this to the attention of the registered manager who explained there had been a change of registered manager in October 2015 and said staff had been well supported but there were no supervision records available. One staff member told us they had been well supported by the previous registered manager who had met with them on a regular basis. We saw that staff visited the office during our visit and contacted the office via the phone and advice and support was offered during these times. For example one member of staff phoned to discuss an ongoing personal concern that was affecting their work availability and this was dealt with in a sensitive and supportive manner. The registered manager gave examples of where they had identified issues and had put in place practical supportive measures agreed with the staff member. For example phoning staff on a frequent basis who required this as part of their support.

However we also noted there were no staff meetings therefore staff did not meet as a group to raise concerns to discuss service information and share good practice. Supervisions were not a regular embedded occurrence. Although there was some informal support the provider was not acting in accordance with their supervision policy and therefore we could not be sure they were giving each staff the opportunity to access the support they required to effectively carryout their role.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt well supported with their health needs. "The caring is good; I have a problem with my teeth and my eyes. They take me out for a coffee as I live on my own. They take me out for appointments too. I feel comfortable with them and I ask them everything. ..they support me, they don't just take me to the appointments but come in and sit with me and talk to the GP too." Another person told us their staff member saved their life when they recognised something was wrong because they knew the person so well and called 999.

Staff we spoke with were knowledgeable about the people they supported and could tell us about people's health support needs in great detail. Staff were given print out information when they worked with people who had a specific condition such as diabetes or Parkinson's Disease to support them to understand the condition and how it might affect the person. Some staff had undertaken their own research to ensure that they understood the condition the person they cared for was diagnosed with. They showed commitment to providing high quality care by working in their own time to understand more about the needs of the person they were supporting.

People had Malnutrition Universal Screening Tool (MUST) assessments when it was appropriate. This is an assessment tool that is used to identify people at risk of Malnutrition or obesity. There was information in their care plan about their general appetite, their specific dietary requirements, and the specialised utensils they used to eat food as well as information as to how they required their food preparation. We saw when one person who was receiving end of life care the staff appropriately monitored their fluid intake. To support one person nutritional needs staff providing care had received training from district nurses to support the person to eat via a percutaneous endoscopic gastrostomy (PEG), this is a tube that is passed into a person's stomach through the abdominal wall, to provide a means of feeding when there is a difficulty with oral intake. The training included cleaning the PEG to ensure the person remained healthy and well.

One staff member told us how they had been caring for a person's feet following the podiatrists and GP advice and had seen a complete recovery due to following the treatment plan. We saw people who had high support needs and were looked after by live in staff were monitored having skin integrity checks, any concerns such as ulcers marked on a body map, daily repositioning charts, food intake and elimination charts. One person at very high risk of pressure ulcers had a bed that gently turned them on a regular basis. Staff monitored the change of position and recorded this in a turning chart. Staff also washed and supported the person with personal care and repositioned the person when necessary. Staff monitored the person carefully and was familiar with changes in their physical presentation.

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 service was aware of their responsibility to protect people's legal rights. Staff described how they asked people's consent before supporting them. There was evidence of written consent being requested for the use of photos being taken, medicines administration support and to share information. Some people's care records recorded that they did not have capacity to consent to their care and treatment but had a relative with Lasting Power of Attorney (LPA) who had a legal right to make health and welfare decisions on the persons behalf. Care plans recorded this and showed where the (LPA) had signed with regard to consent.

Good

Is the service caring?

Our findings

People told us "yes the carers are kind, caring and warm. They offer to help, and are friendly. I am blind, I feel comfortable with them and their voices I can tell. It reassures me" and "I find the carers are generally good, I have had different carers and I have two/three carers on a rota, they are familiar faces." The registered manager told us they aim for continuity of staff and to provide staff people are familiar with. They explained they try to always introduce staff to the people before they support them but that occasionally if there is a last minute change they may not be able to do this. However they always ring people and let them know why staff had been replaced and who they will be. We saw a written compliment from a relative that praised the "sincere, caring, friendly and strong support" provided to their relatives by the staff member.

Care plans identified people's diversity preferences by stating for example "women only carers." People's cultural and faith diversity support needs were specified for example one person's care plan stated they were Jewish and clearly stated what observances need to be made such as eating no shell fish or pork products. Staff told us that they worked under Jewish kosher observances and for example were careful how dairy and meat was stored in the person's kitchen. One staff member described how they prepared food that the person liked, such as spicy foods from a specific cuisine. They told us that they had been taught by the person how they liked their food to be prepared. We saw another staff member had learnt to cook chapattis because the person they cared for liked to eat them each day. Staff were meeting people's diversity support needs.

Staff were respectful when talking about people and showed an empathy with the people they worked with. We observed sensitive interactions when we visited people living in the local community. Care plans specified people's names and what they liked to be called and we saw staff addressed people as the care plan stated with one staff member addressing someone with an abbreviated form of their name as specified and another addressing a person by their title as they had requested.

Staff described how they gave people privacy and respected their dignity whilst offering personal care knocking on their bedroom door before entering to support them. Some care plans were specific about giving privacy for example there were instructions to close the curtains before commencing support for people. Staff had received confidentiality and data protection training.

People told us "yes I do have a care plan, they have come out a few times to review it" and I think I have a care plan. The carers are good, they do what they can and ask if I need anything, I feel safe in their care." Some people were not sure if they had a care plan but said "someone from the agency came out to see me recently to see how things were going." Care plans showed most people and / or their relatives had been involved in their care planning. Live in staff we talked with worked closely with people's relatives to ensure they were meeting the person's wishes. We looked at a person new to the service initial assessment it was detailed and captured the person's wishes. Other care plans had been signed by people or their relatives to show they agreed the care plan content was correct. We saw the service was in the process of changing the format of the care plan to a more accessible format for staff as it had a clearer presentation of people's information. The new formats had been completed following very recent reviews of people's care plans and

they were unsigned as the documents were newly completed but we saw the intention was for them to be signed by people or their relatives. Staff had attended person centred planning training and equality and inclusion induction training to support them to work in a person centred way with people.

People had their end of life wishes in their care plans for example specifying in the event of their death an ambulance is not to be called but to contact a specified family member, another care plan stated the person wanted medical aid in the event of a terminal illness.

Good

Is the service responsive?

Our findings

Most people we spoke with said they felt that staff did what they were asked to and that they read the care plan, describing staff as "good" and "fairly good" and "my personal care is good. I am comfortable with my care …They make me feel as comfortable as they can." But one person said "overall it's a silver star, I think that they need to train the new carers so that I don't have to tell them what to do. I am fed up with that."

Care plans were in the process of changing format we looked at both types of care plan and found although the newer care plans were clearer and more accessible both types of format contained person centred information specific to the individual. The guidance for offering care was clear in each plan. For example guidance for staff in one plan stated that support was required late in the morning and as part of the support the person wanted staff to wash their back for them. Other people's guidance specified how the person must not be left alone and must never be rushed as this would distress them. We saw that the care plans contained guidance for staff that was mostly robust however we raised with the registered manager that one plan we saw, did not contain detailed information as to how the staff could best approach the person when they were distressed. There was some guidance but it could have been more specific. We saw that people's care records had been reviewed to ensure care was being offered as the person wanted it to be delivered. Staff keep daily records of their work with people and the office checked these to ensure the care plan was being adhered to.

The registered manager told us that they had a policy of not agreeing to less than one hour call requests. They explained the reason for this was that they thought they could not offer good personalised care to people in less time. This allowed for the people's personal support specifications to be met and staff could for example talk with people who were living on their own and might not have other company during the day.

The service had systems in place for managing complaints. People told us "yes I can speak to the office, I have their number. I have told them about my complaints. They apologise but they can't do anything because they have to have new carers when my carers go off sick or are on holiday." Another person said "I have made a complaint, my previous carer was quite late and I complained. The carer didn't come back.… so yes the office listened." The service kept a record of complaints made by people and staff. The registered manager investigated and addressed complaints that were made giving feedback to the individual. There was a complaints policy and staged procedure and all people using the service were given a handbook that contained information about how to complain and what response to expect from the service.

Good

Is the service well-led?

Our findings

People were positive about the agency and told us for example "It's a 100% service. It's the care, I've had agencies before and this is the best" and "the work and care is fairly good, so the service is okay too"

There was a registered manager in post and a co-ordinator who had the managerial oversight of the day to day running of the service. There was a director who was actively involved with the service and met often with the registered manager to discuss progress. The provider had their company vision and Rivendell Care and Support values displayed in the office for staff to read. This stated the aim and objectives of the service was "To be an outstanding provider in the UK, creating a brighter tomorrow and a positive difference to people's lives"

The registered manager told us they try and build a good relationship with people using the service and aim to be accessible to them. One person told us "they sent me a birthday card which I thought was very courteous". People told us the registered manager and co-ordinator were always approachable "'Yes the office are pleasant, I have their number. I always get a response and am able to get hold of someone always." The registered manager or the co-ordinator met with people to review their care plans and there was a newsletter sent to all people who used the service. This contained information such as welfare benefits advice, staff charity events, tips to keep well and avoid dehydration in the summer months and service news updates.

The management were available to staff during the day and there was an on call system at night that senior staff as well as the registered manager answered to give advice and support to staff working outside of office hours.

The registered manager showed they valued staff by having a "Carer of the quarter award." The registered manager explained this was when good practice was recognised and rewarded. Describing for example that two staff who had offered support and excellent care to a person who was terminally ill were given the award and one staff member who they consistently had excellent feedback about from the people they supported. The staff given the award are offered a choice of gift, one of which was vouchers for driving lessons; the registered manager explained this has proved popular with staff as it offered them the opportunity to learn a useful skill which they could use for work or their personal life.

The service addressed poor practice such as poor punctuality. The registered manager showed us examples of where they had investigated and addressed staff practice and had worked with staff to support them improve their work practice. Examples were also given of working with staff members to reduce their hours when they worked for long periods without reasonable breaks and reaching an agreement to reduce the length of hours worked.

The registered manager and the co-ordinator audited staff medicines administration records on a monthly basis, also the daily notes and any charts that were used for people's care this had informed them of any improvements required. There was monitoring of care plan provision by calling people and their relatives to

ask them how the care was received and by review of the care plans.

We asked how the service monitored established staff attendance and ensured their work practice was competent .The co-ordinator explained they checked staff time sheets against the scheduled hours. In addition they had three weeks before our visit started undertaking unannounced spot checks on staff. The checks that had been undertaken looked at whether the staff were wearing their uniform and name badge. They checked did they attend at the correct time and was their approach to people good and did they undertake the tasks designated in the care plan and were they using protective equipment appropriately. We saw that only a few checks had been made and that some were booked in the diary for the following weeks. We raised with the registered manager that this is an essential part of monitoring staff performance in a domiciliary care agency. The registered manager gave us assurances that they recognised this was so and were working towards embedding this practice, they confirmed they were in the process of recruiting into a new management position, part of the role was to check staff practice in people's homes. As such we thought the service had recognised the need for more robust auditing in this area and had taken steps to address this concern.

The service worked in partnership with health and social care professionals such as GP, district nurses and local funding authorities.

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 18 HSCA RA Regulations 2014 Staffing Lack of regular supervision and no staff meetings.

The enforcement action we took:

N/A