RA Care Services Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 6 January 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. This was the first inspection of this service since it was registered in April 2015.

The service is registered to provide support to adults living in their own homes with personal care. At the time of our inspection 15 people were using the service. The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We identified major concerns in the provider's ability to meet regulatory requirements. This meant the provider could not demonstrate that they operated systems to deliver a service that was safe, reliable and consistently able to meet the care and welfare needs of people who used the service.

The recruitment procedure was not sufficiently robust to ensure that only suitable persons were employed to work with people. This increased the likely risk to the safety and welfare of people.

Whilst risks to people were assessed prior to them receiving their service, these assessments were not detailed or fully complete. The lack of adequate risk assessments regarding the health, care and safety of people and how to mitigate against them increased the risk that people may receive inadequate and unsafe care.

Staff had limited knowledge of the Mental Capacity Act (MCA) 2005 and how to apply it. This increased the risk of people's rights not being protected in relation to decisions about their care, their right to consent or refuse care arrangements or of best interest decisions being made following the principles of the Act.

People said their nutrition needs were met by family members. However support provided by staff was not clearly stated in their plans.

People's healthcare needs were met and the provider worked collaboratively with other health and social care agencies.

The provider was unable to demonstrate that care met the preferences of people who used the service. Care was developed after visiting and speaking with people who used the service. However care plans did not clearly state people's views and wishes about their care arrangements. This placed people at risk of having care provided that did not meet their needs and wishes.

Whilst people described the responsiveness of the service as being good, we found significant shortfalls in

the provider's ability to demonstrate how they met people's needs. People were consulted about their care as part of the assessment process. However assessments, risk assessments and care plans were not sufficiently developed, personalised or updated. These key documents designed to provide important information about people's needs and service did not adequately guide staff on people's current care and support needs and how to meet them.

The provider could not demonstrate that they took on board the complaints or concerns of people or others involved in their care. The lack of an effectively operated system for identifying, recording, handling and responding to complaints about the care service was a breach of regulations.

There were significant personnel difficulties which presented challenges to the management of the service. There had been a lack of scrutiny and effective quality monitoring of the service. This resulted in widespread shortfalls not being identified or addressed. Management did not use their quality assurance system as a means of developing and improving the quality of service.

People who used the service described staff as being kind, caring and knowledgeable about their needs. Staff received training and supervision and said they felt adequately supported.

We found breaches of regulations relating to safe care and treatment, consent, person-centred care, complaints and good governance in relation to records, quality assurance system and notifications. CQC is currently considering the most appropriate regulatory response to the concerns found and will report on this at a later date. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is Inadequate and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. There was not a robust recruitment procedure to ensure that only suitable staff were employed to work with people.

Risk assessments were insufficiently detailed or complete increasing the the risk of people receiving inadequate and unsafe care.

The provider followed procedures to safeguard people from abuse.

Whilst staff were sufficient in numbers, records did not always clearly show the number of staff attending to people who needed care.

Is the service effective?

Requires Improvement

The service was not effective in some aspects. People's rights to refuse or consent to care arrangements were not protected from staff having limited knowledge of the Mental Capacity Act (MCA) 2005 and how to apply it.

Staff received adequate training, however the provider could not demonstrate that staff were being adequately supported to carry out their roles and responsibilities effectively.

People said their nutrition needs were met by family members. However support provided by staff was not clearly stated in their plans.

The service worked collaboratively with other healthcare professionals.

Is the service caring?

Requires Improvement

The service was not caring in some aspects. Care was developed after visiting and speaking with people, however their wishes or preferences were not clearly identified in their care records. This placed people at risk of receiving care that did not meet their needs and wishes.

People and their relatives said staff were kind and caring and treated them with dignity and respect although records did not always reflect this.

Is the service responsive?

Inadequate

The service was not responsive. Assessments, risk assessments and care plans were not sufficiently developed, personalised or updated. These key documents did not adequately guide staff on people's current care and support needs and how to meet them.

The provider failed to recognise the importance of following complaints through. They did not operate an effective system for identifying, recording, handling and responding to complaints about the care service.

Is the service well-led?

Inadequate

The service was not well-led. There were widespread and significant difficulties presenting challenges to the way the service was managed.

There had been a lack of scrutiny and effective quality monitoring of the service. This resulted in shortfalls not being identified or addressed. Management did not use their quality assurance system as a means of developing and improving the quality of service.

The provider had failed to meet their legal responsibility to notify CQC of significant incidents affecting the safety and welfare of people using the service.

RA 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.

We gave the provider 48 hours' notice that we were undertaking this inspection. This was because the location provides a domiciliary care service and we needed to be sure that someone would be in. This announced inspection took place on the 6 January 2016.

Before the inspection we looked at the information the Care Quality Commission (CQC) held about the service. This included notifications of significant incidents reported to CQC within the past 12 months.

One inspector carried out this inspection, who spoke with one person who used the service, four relatives, the registered manager, care coordinator and five care staff. We looked at four care records, five staff files, records and documents relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People who used the service told us they felt safe when their care was provided and both people using the service and their relatives said they knew they should report any concerns to the office. However, the provider could not assure us that people were kept safe as the systems in place to protect people from harm were not effective.

Staff recruitment documentation was not satisfactory. Staff files did contain satisfactory criminal record checks, identification and current UK residence permits where required. However, whilst all five staff files included two references, one of the files contained a reference that had not been signed by the referee and there was no evidence of its authenticity being verified before the person was employed. In addition the staff member's application form did not provide dates of employment, which the provider is required to check. Similarly, another application form contained only the personal information of the candidate. There were no details of their previous employment or evidence this had been explored with them. This meant the provider failed to ensure that staff had appropriate experience and provided a satisfactory explanation for any gaps in their employment history. When we raised this with the registered manager they told us that the care coordinator, who no longer worked at the agency, had been responsible for recruiting staff. However the registered manager, who had overall management responsibility, failed to check that the recruitment process had been adequately followed and essential recruitment documents were in place for all staff. This meant the registered manager had not taken steps to ensure that people using the service were protected by staff who were adequately vetted to work with them.

The lack of a robust recruitment procedure to ensure that only suitable staff worked with people who used the service was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst risks to people were assessed prior to them receiving their service, these assessments were not detailed or fully completed. We had concerns about the quality of the risk assessments in each of the four files we looked at as risks were not clearly identified and there was a lack of information for staff about how to mitigate any risks that were identified. In addition, not all of the risk assessments were dated and there was no evidence to show that they had been reviewed or updated to ensure they reflected people's current needs. For example, the moving and handling risk assessment for one person identified their need for full assistance with certain activities and two staff to assist them. There were no details in the person's care plan that reflected the support they needed to minimise the risks identified. Their care plan contained little information, giving staff no indication of what assistance they needed, including how many staff were required and daily notes were not clear or specific enough to determine if the person received the help they needed. Another risk assessment ticked that the person had mobility needs, with no further mention of what the specific needs were and how they should be met to ensure their safety. These issues increased the risk of people receiving inadequate and unsafe care.

The registered manager and care staff informed us that they followed their policy of only prompting people to take their medicines, not to administer them. However, in the daily care delivery records of two files we

looked at this was not clear. One staff member recorded they had 'given' medicines to a person while in another file the staff member wrote only the word 'medication,' not clarifying what type of medicine support they provided. In addition, we found that assessments of people's individual needs and care plans did not state people needed prompting to take their medicines as part of their care package. This placed people at risk of not receiving their medicines as prescribed because the provider did not have a safe system of medicines management in place.

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

There was evidence of the provider following procedure to safeguard people from abuse. Staff were knowledgeable about the signs of abuse and how to protect people if they had concerns. There had been two allegations of abuse concerning inappropriate care and neglect. One was still being investigated by the local authority and the other was closed and required no further action. The provider had notified the local authority safeguarding team after becoming aware of these allegations in line with their procedures.

The five staff files we looked at contained forms signed by staff confirming they had read and understood the safeguarding policy and procedure. Staff we spoke with showed they could recognise signs of abuse and would take action by taking steps to ensure the person was kept safe and reporting their concerns to the registered manager.

Staff were sufficient in numbers, however for one person assessed as needing the support of two staff for help with personal care, we found daily care notes with the signature of only one staff member, not two which implied that only one person had attended the visits. The registered manager told us they knew that two staff members had attended the visits as all staff members were required to visit the office weekly to submit their timesheets. He told us that the staff member had failed to sign the records and accepted that he had not identified this omission or addressed it with the staff member concerned.

All staff were provided with a staff handbook, providing information about expected codes of conduct and key procedures. Staff undertook a probationary period of three months and offered contracts if their performance was satisfactory. Staff we spoke with were aware of the whistleblowing procedure where they could safely report any concerns about the service. However they told us they felt there had been no need to use it so far.

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. The registered manager advised that most of the people who used the service were unable to make decisions for themselves. He advised that where this was the case their next of kin made decisions for them. There was no evidence in the files we looked at of capacity assessments being undertaken or best interests decisions being made where there were concerns about people's ability to make specific decisions about their care. Staff we spoke with had limited knowledge of the Act and how to apply it. The provider could not assure us that they were meeting the requirements of the MCA and that people's rights were protected.

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

Staff received a two day classroom based induction training and were given course materials including access to e-learning as part of their induction. This covered a range of topics that the provider considered were mandatory to suit people's needs, including moving and handling, health and safety and safeguarding people from abuse. The induction also included shadowing more experienced colleagues for a period of up to a month. Staff had also been given refresher training to help ensure their knowledge and skills remained up to date. We saw evidence of this training in staff files.

The registered manager told us they had supported more than 15 staff to complete national vocational training in health and social care and the majority of staff had attained these qualifications at various levels.

Staff told us they felt they had sufficient training. For example, one care worker told us they had a diploma in social care and had received a range of training, such as safeguarding adults, moving and handling, infection control and food safety, as we saw in their files. Staff said they received supervision and annual appraisals and said they felt supported. Records showed that whilst appraisal meetings had occurred, the appraisal forms had only been completed by the staff member, and there were no comments about the staff members performance or development needs from their manager. One member of staff had recorded that they wished to have more training, but there was no action linked to this. Therefore the provider could not demonstrate that staff were being adequately supported to carry out their roles and responsibilities effectively.

Staff informed us that people were supported with their nutritional needs but said that most people were supported by their family members. We were told that in some cases, care workers prepared food according

to people's needs. However it was not possible to assess the extent to which people were being supported in the records, due to the lack of sufficient detail in assessments, care plans and care delivery records. However we spoke with relatives, who confirmed that they purchased food and staff prepared meals according to the needs and wishes of their family members.

We saw correspondence with healthcare professionals which indicated that people were assisted to have access to ongoing healthcare support. For example, where one person was nearing the end of their life, the provider had worked with other health and social care professionals involved in the person's care to plan and coordinate their care. In another example, one staff member told us about how they had contacted the registered manager after a person took the wrong medicine prior to the person being prompted to take their medicines by staff. The registered manager immediately contacted the person's doctor and other health and social care agencies involved in the person's care to seek advice and support and ensure the person's needs were met.

Requires Improvement

Is the service caring?

Our findings

People using the service and the relatives we spoke with told us that the provider had visited them to carry out an assessment of their needs and asked about their preferences regarding the care and support they required. The registered manager also told us that care plans were developed in consultation with people who used the service. However, the care plans we viewed did not clearly state people's wishes or preferences about their care. Therefore there was no evidence that the preferences people discussed during their needs assessments were included and taken into account when developing their care plan. This placed people at risk of receiving care that did not meet and respect their individual wishes.

People using the service and the relatives we spoke with were consistently positive about the caring attitude of staff. They told us staff understood their needs and wishes and had developed positive relationships with them. Relatives told us that staff promoted people's dignity and treated them respectfully at all times. They said staff understood their language, cultural and spiritual needs and demonstrated this in the way they provided care. All said staff were kind, caring and compassionate.

However, we were concerned about the use of inappropriate language used by some care staff when completing people's daily care records, which did not show the level of dignity, respect and professionalism that would be expected. For example, staff repeatedly recorded that they changed people's 'nappies' rather than using a more age appropriate term such as incontinence pads.

People using the service and their relatives told us they were supported to express their views and said that staff had given them the information they needed about the service. Staff knew people's individual communication skills, abilities and preferences. For example, one staff member told us they consulted relatives to assist them in understanding one person's communication needs and sign language. They said that as a result they were becoming more skilled at communicating with this person. This was confirmed by the relative we spoke with who told us they worked closely with staff and were very happy with the skills and caring attitude of staff.

Rotas were organised so that people received care from a small number of consistent staff who understood their needs and built a relationship with them. People using the service and their relatives confirmed that care was consistent and that they had the same care staff who were reliable.

Inadequate

Is the service responsive?

Our findings

People using the service and their relatives consistently said that staff were responsive to their needs and told us they were satisfied with the service. However, we found significant shortfalls in the provider's systems that meant we could not be assured that people's individual needs were always met.

People were consulted about their care as part of the assessment process, however assessments, risk assessments and care plans were task- based and basic, incomplete and did not include people's personalised needs. Therefore they did not provide adequate guidance to staff about people's current care and support needs and how to meet them. Daily care notes recorded by staff were task-based and lacked sufficient detail about how people's individual needs were met.

Correspondence we saw with funding authorities and discussions we had with people using the service and their relatives confirmed that people's needs were reviewed and care and support adjusted to reflect their changing needs. However, these changes were not recorded and key documents, including care plans, were not updated. The registered manager said they became aware of any changes when they met with staff on a weekly basis when submitting their timesheets and through their regular contact with people who used the service. We saw evidence that people were being regularly contacted or visited to check their satisfaction with the care, however records of these contacts were not sufficiently detailed and actions arising out of these contacts not recorded.

We received feedback from people using the service and their relatives that staff turned up on time, stayed the allotted time and would always contact them if they were running late. However there was a lack of clarity over the frequency and times of visits when comparing these against the care records and care plans. For example, only one or two visits were recorded in the daily notes for one person when their care plan identified that they required three visits a day. The registered manager told us they believed the person was receiving care as needed as they received good feedback about the service provided. Also people had to sign the care staff time sheets confirming their call times. However the registered manager accepted that recorded care times in daily care notes did not always correspond with the agreed care and support as stated in people's care plans. There was no evidence that the registered manager had identified this as an issue of concern to discuss with staff or investigated this further. There were discrepancies of this kind in all of the care records we looked at.

The issues above increased the risk of people receiving inadequate care that didn't meet their individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and staff we spoke with said that if people had minor issues and were dissatisfied, they dealt with people's concerns as they went along. A complaints policy and procedure was in place and all those we spoke with said they had received information from the provider that explained how to complain. However one relative told us that they found a number of staff were not carrying out the care that was needed and had complained on numerous occasions about this. We asked the registered manager for

details about these complaints, how they had been investigated and the outcome. Whilst the registered manager knew about these complaints, they could not provide records demonstrating how they handled the complaints, whether the complaints were responded to, investigated, substantiated, addressed or that any action was taken to make changes or improvements as a result of the complaints.

The lack of evidence that the provider had established and operated effectively an accessible system for identifying, recording, handling and responding to complaints was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

People were not protected from unsafe or inappropriate care as the provider's systems for managing and monitoring the service were ineffective. The registered manager told us he was aware that improvements were needed and said that personal circumstances had impacted on his ability to manage the service. In addition, two managers had recently left their employment. The registered manager said they were about to advertise for another manager. He had also recently recruited a care coordinator and administrative assistant, who were completing training in relation to the requirements of their roles.

There was a lack of structure to the way in which care and support was organised and provided to people using the service which increased the risk of potential errors and avoidable harm. There was a lack of leadership to ensure that regulations were met and that staff had the necessary guidance they needed to meet people's needs safely and effectively. There had been a lack of scrutiny and effective quality monitoring of the service which resulted in shortfalls not being identified or addressed. There was no evidence that the management team had used their quality assurance system as a means of developing and improving the quality of the service.

Quality monitoring was limited to visits or telephone calls to people after six to eight weeks of them receiving a service and then regular telephone calls or visits to check their satisfaction with the service. Spot checks were carried out by the registered manager or care coordinator at people's homes every month to two months and people confirmed they had ongoing contact with the agency. However, there was a lack of documentary evidence to demonstrate that issues were identified and addressed effectively.

Areas of concern identified during our inspection included poor and unsafe recruitment procedures; lack of effective assessment and care planning; inadequate risk assessments; poor quality of records and a lack of evidence that care was delivered according to assessed needs. There was a lack of transparency around the handling of complaints as complaints investigations and outcomes were not recorded. Issues of poor performance were not picked up and addressed with staff, such as the inappropriate use of language in daily care records, and the lack of consistency and clarity in the frequency and times of visits and tasks carried out. The provider had also failed to adequately meet the requirements of the Mental Capacity Act 2005.

We saw no evidence that the provider's monitoring systems would identify any patterns or trends that would highlight potential risks or areas for development.

The issues above evidence inadequate leadership and a lack of effective systems for monitoring, and improving the quality and safety of the service provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been a failure to recognise and comply with the legal obligation to notify CQC of allegations of abuse. The registered manager stated they were unaware of this responsibility to report safeguarding concerns to CQC as they thought it was sufficient that they had reported concerns to the local authority

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

The registered manager told us that he was committed to improving the service and believed he would be able to implement the necessary changes required to ensure the regulations were met once they recruited another manager and addressed the management issues. However whilst these changes were in progress, they had not yet taken effect by the time of this inspection.

Staff were positive about the open culture of the organisation and said they attended regular team meetings where they could discuss practice issues related to people who used the service, as we saw in minutes of team meetings.

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 did not take formal enforcement action at this stage. 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 The provider failed to ensure their legal responsibility to notify the CQC without delay of allegations of abuse as part of the system to monitor and protect the people who use the service. Regulation 18 (1)(2) (e) CQC (Registration) Regulations 2009, Notification of other incidents

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were at risk of receiving inappropriate care by the provider's failure to demonstrate that care was appropriate to meet their assessed needs and wishes. Regulation 9 (1) (a) (b) (c)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights were not protected by the provider failing to apply the principles of the Mental Capacity Act 2005 when seeking consent about their care. Regulation 11 (1) (3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from the provider doing all that was reasonably practicable to assess the risks to their health and safety and to mitigate any such risks. Regulation 12 (1) (2) (a) (b) The provider had not ensured that care was provided in a safe way for service users as they had not ensured the proper and safe management of medicines. Regulation 12 (1) (2) (a) (g)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints People were not protected from the lack of an effective procedure and handling of complaints. Regulation 16 (2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were at increased risk of their service not being adequately run by the lack of effective systems or processes to regularly assess, monitor and improve the quality and safety of the services provided. Regulation17 (1) (2) (a) (b) People were not protected by the lack of accurate, complete and contemporaneous records of the care provided to them. Regulation17 (1) (c)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People who use services were not protected against the risks associated with the lack of a robust recruitment procedure. Regulation 19 (1)(3) (a)