

G P Homecare Limited

# Radis Community Care (Stoke-on-Trent)

## Inspection report

15 Hill Street  
Stoke On Trent  
Staffordshire  
ST4 1NL

Tel: 01782412200  
Website: [www.radis.co.uk](http://www.radis.co.uk)

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15 November 2018

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

**Requires Improvement** 

Is the service effective?

**Requires Improvement** 

Is the service caring?

**Good** 

Is the service responsive?

**Good** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

We inspected this service on 22 and 23 October, with follow up calls to people, relatives and staff taking place up to 15 November 2018. This was an unannounced inspection. At our last inspection published in December 2015, the service was rated good overall. However, at this inspection we found the service was not rated as good overall and there were breaches of regulation. You can see what action we told the provider to take at the back of this report.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to people with a physical or sensory disability, older adults, younger adults, those living with mental health issues or dementia or people who may have a learning disability. At the time of our inspection there were 217 people using the service.

There was 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 and associated Regulations about how the service is run.

People were not always protected from potential abuse and things were not always learnt when things went wrong as timely action was not always taken. Systems were not always in place to monitor trends in incidents and systems in place were not always effective at improving people's experience of their care.

Notifications were not always submitted, as required by law.

Risks were not always assessed and planned for as details of risks to people and staff were not always detailed in people's care plans. We could not be sure that people were always receiving their medicines safely as instructions were not always followed, or were not always available.

People were not always supported to have maximum choice and control of their lives; the policies and systems in the service did not support this practice. The principles of the Mental Capacity Act (MCA) 2005 were not always being followed.

Staff were recruited safely; however, there was mixed feedback about staffing levels and not all calls were on time, but action was taken to address this.

Staff received an induction and ongoing training, however this was not always effective or updated in a timely way. Staff also had mixed feedback about how supported they felt.

Staff followed infections control measures to help keep people healthy. People were also supported to have a diet of their choice and were supported to access other health professionals when necessary.

People and relatives felt staff were kind and caring and treated with dignity and respect when being supported. People were encouraged to be independent and could make choices about their care.

People were involved in developing their care plans and people and relatives were involved in reviews which contained personalised details about people's routines.

People knew how to complain and felt able to. We saw complaints were investigated and responded to. People and relatives were able to feedback about their care and staff were able to attend meetings to discuss changes with the service. Staff felt the manager was approachable.

End of life care for people had been considered, although few people required this at the time of the inspection.

We have made one recommendation in the main body of the report to recommend steps are taken to ensure people with all protected characteristics are actively supported and protected, when necessary. We also identified two breaches of regulation and you can see the action that we have asked the provider to take at the end 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?

The service was not consistently safe.

People were not always protected from potential abuse as there was a lack of oversight of concerns.

Risks were not always assessed and planned for.

Lessons were not always learned from incidents.

People's medicines were not always safely managed.

There was mixed feedback about timeliness of calls but safe recruitment practices were followed to ensure appropriate staff were working with people who used the service.

Infection control measures were in place.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective.

The principles of the Mental Capacity Act 2005 (MCA) were not always followed as mental capacity assessments had not always been carried out when necessary.

Staff had received induction and training however some staff needed refreshers and could not always answer questions.

People were supported with their nutritional intake when necessary.

People had access to health care services.

The service often used information from the local authority to check they could meet someone's needs.

**Requires Improvement** ●

### Is the service caring?

The service was caring.

People told us the staff were kind and caring.

**Good** ●

Privacy and dignity were respected and people were supported to maintain their independence.

People were involved in decisions about their care.

### **Is the service responsive?**

**Good** ●

The service was responsive.

People were involved in developing their care plans.

People knew how to complain and felt able to.

The service had considered people's end of life care.

### **Is the service well-led?**

**Requires Improvement** ●

The service was not consistently well-led.

Necessary notifications were not always being submitted.

Quality monitoring systems were not effective at ensuring the service was being managed appropriately and safely.

People and relatives were asked for their opinion about their care.

More work was required to ensure people were appropriately supported in relation to their protected characteristics.

# Radis Community Care (Stoke-on-Trent)

## **Detailed findings**

### **Background to this inspection**

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

The office inspection took place on 22 and 23 October 2018, with phone calls to people and relatives on the 24, 25 October 2018 and 15 November 2018. The inspection was unannounced. The inspection was carried out by two inspectors. There was also an Expert by Experience who made phone calls to people who use the service and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at information we held about the service including statutory notifications submitted. Statutory notifications include information about important events which the provider is required to send us by law. We contacted Healthwatch and local commissioners to seek their views on the service provided. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care services.

We spoke with nine people who used the service, six relatives and nine members of staff. We also spoke to the registered manager, the deputy manager and the area manager. We reviewed the care plans and other care records (such as medicine records) for ten people who used the service. We also looked at management records such as quality audits and training records. We looked at recruitment files for four members of staff.

## Is the service safe?

### Our findings

Action was not always taken in response to accidents, incidents or information of concern in a timely way to keep people safe. We saw and were told of other examples, of action not always being taken in a timely way. Another local branch had recently closed and people's care was transferred to the Radis Community Care (Stoke-on-Trent) branch. Paperwork relating to people's care was all transported to the Stoke-on-Trent branch. When the paperwork was being sorted multiple accident or incident forms were found and it could not be determined if action had been taken to reduce the likelihood of an incident reoccurring. When the incidents occurred the registered manager for the Stoke-on-Trent branch was not responsible for monitoring the care people from the previous branch received. However, once these forms had been found by staff in the Stoke-on-Trent branch and collated into a file, there was still no evidence action had been taken to ensure people remained safe and risks to their health and well-being were being incorporated into their care and support. There were also no safeguarding records kept so it was not possible to easily check if the service was ensuring they were reporting all concerns and keeping people safe. We saw that over 20 staff had their safeguarding refresher training outstanding which meant not all staff were up to date with this, which could impact upon their ability to recognise and take action, such as reporting, potential abuse. This meant people were not always being protected from potential abuse and lessons were not always being learned as there was no systematic oversight and review of safeguarding incidents and ensuring risks to people's health and well-being was systematically reviewed.

Risks were not always assessed and planned for. For example, it was documented that one person had occasions when they would become agitated and display behaviours that challenge. There were multiple documented instances when the person had been physically aggressive towards staff however there were no mention of this in the person's care plan. If staff are not made aware of a person's possible behaviour this could put both the person and staff at risk as staff may not respond in the best way for that person. Another person was noted as requiring oxygen to help their health condition. The use of oxygen can be a risk due to the high-pressure storage, however, no specific risk assessment was in place for the person or guidance for staff to follow in relation to this. Other people were also noted as being at risk of pressure damage to their skin. There was no formal assessment of the level of risk to some people, such as using a nationally recognised best practice tool, which can indicate the risk level and assist in planning for how to reduce the level of risk of people's having skin damage.

People did not always receive their medicine's as prescribed. We saw one person had a prescribed patch which staff applied. The care plan stated the application of this patch should be documented on a body map so it could be clearly determined where on the person's body it had been applied. This is because the guidance for this medicine recommends the patch is not applied in the same place for a period of time as this can cause side effects – such as skin irritation or thinning of the skin. A body map was not being used so it was not being documented where the patches were being applied, which meant the person was at risk at having them applied in the same place which could cause unnecessary side effects. Some people had medicines that were needed 'as and when required', also known as PRN medicines. There was not always guidance in place to help staff know when this medicine was or was not required. We saw that Medication Administration Records (MARs) were in place which documented which medicine people had and when they

had it. MARs were printed with the dosage and instructions present, however there were occasions when instructions were not always clear. For example, one person was prescribed a medicine that could be 'one or two' tablets. However, there was no guidance for staff to know when it should be one or two tablets. Some instructions for medicines were also ambiguous in the way in which they were written which put people at risk as staff may not always be clear when the medicine was needed. Staff were regularly signing MAR to indicate whether a medicine had, or had not, been given. However, due to the ambiguity with some of the instructions, we could not always be sure the medicine had been administered or prompted correctly. Therefore, we could not be sure that people always had their medicine as prescribed.

There was mixed feedback about staffing levels. Some people felt they did not have consistent call times. One person said, "I used to get my calls on time but lately they seem to get later and later. I am sure they keep putting extra calls in before mine, it's as though the calls come before the client." However, other people and told us they generally received their care on time. One person said, "My calls are usually on time I never really have more than 5 minutes to wait after the time on my rota." Another person said, "My carers come when they are supposed to and I am never rushed." Another person said, "I have two calls a day and if anyone is ever going to be late I get a call from the office to tell me." However, staff told us they were not always enough staff. One staff member said, "We are short staffed; a lot of people are off sick." The same member of staff went on to say, "Sometimes our rota is not achievable, sometimes we are behind because we are not given enough travel time, I don't think they realise how far each of the calls are away from each other." A social care professional said, "[The service] have had some difficulty delivering on the service specification due to staff shortages." The service also confirmed they were being proactive to ensure all care calls were covered by using agency staff as they were unable to always cover calls with permanent employees of Radis. This meant, that despite not all calls being at the time expected, action was being taken to address this to ensure all visits took place.

We saw that staff were recruited safely. Staff files included application forms and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) (criminal records check) to make sure people were suitable to work with people who used the service. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant. We saw appropriate risk assessments were in place if a member of staff had a positive DBS.

People told us that staff followed infection control guidance by wearing aprons and gloves when necessary. We saw that staff received infection control training and there was a policy in place. This meant infection control measures were in place to help protect people.

## 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. Decision-specific mental capacity assessments should be undertaken to determine if people have the capacity to make certain decisions such as consenting to their care and care planning, if it is suspected they may not have capacity.

We found mental capacity assessments were not being carried out if it was suspected someone may not have capacity to make particular decisions. A person who has Lasting Power Of Attorney (LPOA) for health and welfare has the legal right to make decisions and sign agreement on behalf of someone who has lost their capacity to make their own decisions. Relatives were signing consent on behalf of people without their legal authority being checked. We also saw an example of a person who was noted to not have capacity, although it was not clear which area the person did not have capacity in. They had signed agreement to their own care plan, however records suggested the person would not effectively be able to consent to their care plans. When we spoke with staff some were unclear about what mental capacity was and none could answer questions about what the MCA meant for people. This meant people were not always being supported in line with the MCA.

There was mixed feedback about how supported staff felt. One staff member said, "I have not had any supervision, and not had any spot checks either or anything like that." Another member of staff said, "I don't really feel supported, no." Staff received an induction when they first started and were supported to refresh their training periodically. People and relatives told us they felt staff were well trained. One person said, "I couldn't ask for better care, without Radis I don't know what I would do." Another person told us, "My carers all seem to know what they are doing so it really gives me confidence in them." A relative said, "I think my relative's carers are very well trained and nothing seems to be a trouble to them." A staff member told us, "I went to stoke office, they took me through different areas of care in a small group" and they went on to say, "I went out into the community, I was shadowing for two days. They then they wanted me to go out on my own but I wasn't ready. I told the office that I wasn't ready; I ended up doing four more shifts shadowing, this helped. After this I felt this made me feel equipped me to do my job." However, we saw training was not always up to date for some staff and some staff were unable to effectively answer questions. Some staff required refresher training in moving and handling, medicines and infection control. Due to some safeguarding incidents not being reported or recognised, staff did not always have an effective understanding of how to protect people from potential abuse.

People were supported to have food and drinks when required. One person said, "My carers do my meals each day and I always get what I want and its lovely." A relative said, "My relative is not really capable of doing things for themselves even though they think they are doing everything they used to. Without the carers my relative wouldn't even eat." There were details in peoples care plan as to whether they need support to make their meals and we saw that if they did, this was being documented in people's care

records. We saw if a person had additional advice from a Speech and Language Therapist (SALT) this had been incorporated in to the person's plan for staff to follow.

The service often relied on care plans completed by the local authority social workers to determine if they could meet a person's needs. Following this, the service then assessed and developed a care plan to be used by staff to guide them to support the person. This meant the service considered people's needs and whether they could meet them.

People were supported to access other health professionals when necessary and relatives were kept informed. One relative said, "I am always informed usually by my relative's wonderful carers when there is any kind of problem." We saw that there was input from social workers, district nurses and SALT. This meant people were supported to access other services where necessary.

## Is the service caring?

### Our findings

People and relatives told us they found staff kind and caring. One person said, "I call my carers my angels I couldn't manage without them." Another person said, "I do feel that its more than a job to most of the carers." Another person told us, "Nothing is ever to much trouble, we [person and staff] have a real good laugh most days." A relative said, "The staff are amazing." All people spoken with said they were treated with the utmost respect at all times.

People were supported to maintain their dignity and independence where possible. One person told us, "I am treated at all times with respect and the carers always maintain my dignity by keeping me covered when they can when they help me to get ready." A relative said, "I am not always there when the carers come, but I do know they always ask my relative what clothes they would like to wear. I like that as it still helps my relative to be a little bit independent." All people we spoke with confirmed their dignity was maintained at all times during personals care.

Staff were able to give us examples of how they supported people to help maintain their privacy and dignity. One staff member said, "I make sure that curtains are shut and doors are closed. For personal care, if I am washing I tend to do one half then the other half [of a person's body]. I tell the person what I am going to do before I do it, I guide them through it so wherever I touch next is not going to be a shock." Another staff member said, "For bathing support I cover them [person] with a towel." People's right to privacy was respected as we also saw that people's care plans were stored securely so that only those who needed information about people could access it.

People were able to make decisions about their care. One staff member said, "When we go into homes I ask what people want on that day. It's their choice, it might say shower on the care plan but it's their choice and their right not to have one If they don't want one"

## Is the service responsive?

### Our findings

People and relatives told us they were involved in developing their care plan and were supported by staff. One person said, "I have just started back with Radis and my needs have not really changed but I had full assessment for a new care plan done again." Another person said, "Yes I have a care plan. My carers write everything down they do for me in it. I don't look at it but my relatives does because I forget things." One relative said, "Without the support of her regular carers I feel that things could go very wrong." Staff told us they were able to read the care plans and that they mostly contained enough information. One staff member said, "The care plans are ok. I think they are individual and about what people want." Another member of staff said, "The care plans cover people's preferences, they say what they would like from the carers, it covers cultural needs and religious needs, it also states what things they like to do going to certain clubs on certain days." Another staff member commented, "The care plans tell you things like, how many sugars a person has, what kind of perfume they use - all the little kind of details." We saw that plans contained personal details such as how people liked to be supported and a routine they preferred. Plans were reviewed at least annually and we saw changes were made to plans based on these reviews, when necessary. This meant people were supported and staff were guided to have care in a way they preferred.

People knew how to complain if they needed to. One person said, "Everything I need to know from how to complain to who to contact is in my care plan." A relative told us they had some concerns about an aspect of their relative's care, but they spoke with the staff directly and it was resolved, and the concern has not happened again since. We saw that when complaints were made, an investigation took place, a response sent to the complainant and action documented in response to the complaint. There was an appropriate complaints policy in place with contact details in for alternative organisations that can support people if they were not satisfied with the response from the service. We also saw that when feedback had been received by the local authority and shared with the service, this feedback was also looked into and responded to, in order to improve the service.

At the time of our inspection, few people were needing support who were nearing the end of their life. However, we saw, when necessary, consideration had been given to this and if someone was aware they had a life-limiting illness then this was incorporated into their care plan.

## Is the service well-led?

### Our findings

Notifications had not been submitted, as required by law. Notifications include information about allegations of abuse that have been referred to the local authority. Despite some concerns having not been reported, some concerns had been referred to the local safeguarding authority and we had not received the corresponding notification for these. When we spoke with the registered manager about this they said, "We haven't submitted a safeguarding notification. We haven't had any safeguarding referrals." Following further reflection and checking that safeguarding referrals had been made the registered manager and area manager acknowledged that they had not deployed effective systems to ensure that notifications were submitted to us about important events. This meant we were unable to verify if the service was taking appropriate action to keep people safe and for us to monitor the service.

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

Systems were not in place, or were not fully effective at always identifying improvements needed to ensure people's experience of their care improved. Safeguarding incidents were not analysed or monitored centrally to identify trends. Issues had not always been reported and action taken to resolve concerns and action taken to ensure risks to people's health and well-being were incorporated into their care plans. A member of staff told us, when they tried to report concerns, "They [the office] think they know best. I tried to report a [a concern] and [the office staff response] were just dismissive towards me." A social care professional also commented upon the small number of referrals made by the service in relation to safeguarding. Some staff told us that that the management of the service did not always respond to things in a timely manner. One staff member said, "I don't think [registered manager] understands the urgency. The [registered] manager is someone you should go to for instructions and guidance but we don't always get that." Another member of staff said, "There is no care plan in place for a piece of equipment and I reported it to the office over a week ago and there still isn't one in place." Another staff member said, "I can ask and ask and it doesn't always get dealt with." A social care professional we spoke with said, "Radis also very rarely report missed or late calls. I'm not sure they have sufficient reports or systems in place when looking at punctuality of calls." We also found that our requests were not always responded to within the timeframe set. A recent quality assurance visit had taken place by the provider which identified some areas which we had also found during the inspection. This included areas to improve about assessing people's capacity and ensuring risk assessments contained sufficient information. However, an action plan or timescales had not been set to address these issues in a reasonable timeframe. Timely action had also not always been taken in response to incidents being discovered. When we spoke to the registered manager about the reporting and consideration of concerns regarding potential incidents or abuse, they said, "Due to lack of knowledge of [some staff] sometimes we weren't finding things out for weeks. We've had a meeting about reporting things." We saw multiple accidents or incidents that did not have any clear action taken into response to them despite them being found by Stoke-on-Trent office staff, after they took over people's care from another office which closed. Some staff training was also significantly out of date, despite it being required annually as specified by the training records, so insufficient steps had been taken to bring this up to date within a reasonable time. This meant systems were not always effective at identifying and taking action in response to concerns.

We saw some audits had been effective and MAR charts were being checked, however some of these checks had not identified potentially ambiguous guidance being given to staff or when body maps were missing, when they had been required. Reviews of people's care files were not evidenced as having been carried out in the branch, so issues were not always being identified, such as lack of particular risk assessments and information not always being in people's care plans. This meant action was not always taken to improve people's care.

Audits were carried out on the care notes. We saw many of these had been effective. It was explained to us there was a process in place to support staff to improve it had been identified that they were repeatedly making mistakes. This involved making them aware that improvements were needed, meeting with the carers to go over any concerns, re-training and then it may result in meeting with the registered manager if improvements were not made. During the inspection, and since our visit to the office, it was explained to us that new processes were being put in place to make improvements to the branch. The area manager had also re-introduced the use of a 'quality report' monitoring how many staff had training outstanding, supervisions and which people had reviews outstanding to monitoring the service more closely. The registered manager explained to us that there had been a, "Breakdown in communication around who is responsible for tasks." They explained in response to this, a new 'process folder' had been very recently introduced which defined different people's job roles and handy 'how-to' lists staff could follow, such as what action to take if there was a medicine error, or if there was a missed visit, for example. A 'lessons learned' log had been put in place recently so the registered manager was beginning to have an oversight about when things had gone wrong. However, this was not fully embedded so we were unable to check how effective this had been so far.

People and staff were frustrated with changes to rotas and communication with office-based staff. One relative said, "I feel sometimes the carers themselves get frustrated, especially when calls are late as they have no choice when extra calls are scheduled." Another relative commented, "I sometimes think, when I ring the office, that what I tell them is not really taken notice of or passed onto the person who really needs to know. I know this because I don't always get a follow up call." Another relative told us they 'usually' had the same carers but already that week their relative's rota had been changed with them not being told, which caused them distress. One member of staff said, "They [the office] will change the rota at short notice and they won't inform you. They did it once where they changed my rota through the day" and the staff member went on to say, "I was ending a call at 4pm and was having to start another call at 4pm, so I left my house early so I could start my calls early. This makes me feel quite anxious and stressed." Staff also commented, "Nothing professional about the office." This meant some people felt communication could be improved to ensure they were kept informed of changes.

There was an 'Equality and Diversity' policy in place which took account of the protected characteristics (such as gender, race, religion, sexuality etc). We saw that people's religion had been recorded so that staff were aware. We viewed the Provider Information Return (PIR), completed in November 2017, as part of planning for the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. The PIR noted that no work had been undertaken to ensure the service met the needs of people with protected characteristics, as specified in the Equality Act 2010. When we asked the registered manager about what had been done since the PIR was completed, they said, "I haven't done anything." They went on to say, "We have sent out surveys to gather people's opinions, but nothing in particular [about people with protected characteristics]." Therefore, the service could not always effectively demonstrate how they were supporting people in relation to their characteristics. We were told of an example whereby a person was not always supported with their care staff of choice, which caused them distress. We recommend steps are taken to ensure people with all protected characteristics are actively supported and protected, when necessary.

The above constitutes a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw people and relatives were asked for their opinions about the service. A survey had been sent out for people to respond to, however this had not yet been analysed as the survey had only just been sent out. We saw many positive responses had been received so far. An action plan had been developed following the last survey in 2017. Staff were also able to attend staff meetings to discuss changes in the service, such as the branch covering new geographical areas. Staff felt the registered manager was generally approachable. There was also a national newsletter sharing news from across the company. One staff member said, "I have a good working relationship [with the registered manager]."

The registered manager worked with other organisations. For example, they engaged an agency to support with staffing levels. It was noted that improvements were needed to how agency staff recorded the support they were giving to people. The registered manager was proactive in meeting with the agency to discuss feedback and they worked together to make improvements.

The rating from the last CQC inspection was being clearly displayed on the provider's website and within the office, as required by law.

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 17 HSCA RA Regulations 2014 Good governance  Systems were not always effective at identifying or ensuring timely action was taken to ensure people's experience of their care improved.