G P Homecare Limited

Radis Community Care (Eden Place ECH)

Inspection report

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Date of inspection visit:
05 February 2018

Date of publication:
09 March 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Radis Community Care (Eden Place ECH) provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. The Care Quality Commission (CQC) does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

People using the service lived in a single building with 55 ordinary flats in the town of St Ives. Not everyone using Radis Community Care (Eden Place ECH) received the regulated activity 'personal care'. CQC only inspects the service being received by people provided with 'personal care', that is help with tasks related to personal hygiene and eating. Where they did, we also took into account the wider social care provided. There were 22 older people, receiving the regulated activity of personal care at the time of this inspection.

This inspection took place on the 5 February 2018 and was announced. We gave the service 48 hours' notice as we needed to make sure that staff would be available. This is the first inspection carried out at this service since they registered with the CQC on 27 January 2017.

The CQC records showed that the service had a registered manager. However, they were unavailable during this inspection. 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.

Staff had an understanding of the Mental Capacity Act 2005 (MCA). People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Staff knew how to report any suspicions of harm and poor care practice.

People were assisted to take their medication as prescribed. Processes were in place and followed by staff members to ensure that infection prevention and control was promoted and the risk of cross contamination was reduced as far as possible when supporting people.

Staff assisted people in a caring, patient and respectful way. People's dignity and privacy was promoted and maintained by the staff members supporting them.

People and their relatives were given the opportunity to be involved in the setting up and review of their or their family member's individual support and care plans.

People were supported by staff to have enough to eat and drink.

People were assisted to access a range of external health care professionals and were supported by staff to maintain their health and well-being. Staff and external health care professionals, would, when required, support people at the end of their life, to have a comfortable and as dignified a death as possible. However, people's end of life wishes were not documented for staff to use as guidance should they need this and staff had not received training relating to end-of-life care.

People had individualised care and support plans in situ which documented their needs. These plans informed staff on how a person would like their care and support to be given, in line with external health and social care professional guidance.

There were enough staff to meet people's individual care and support needs. Individual risks to people were identified and monitored by staff. Plans were put into place to minimise people's risks as far as possible to allow them to live as safe and independent a life as practicable.

Accident and incidents that occurred at the service were recorded. However, these records were not always complete. This meant that there was information missing such as, whether an injury had been sustained following the incident and what actions had been taken to reduce the risk of recurrence. This meant that these records did not demonstrate that they were reviewed as part of the on-going quality monitoring of the service, to reduce the risk of recurrence and drive improvements forward.

There was a recruitment process in place and staff were only employed within the service after all essential checks had been suitably completed. However, not all staff recruitment files evidenced that all of the checks had been completed. Staff were trained to be able to provide care which met people's individual needs. The standard of staff members' work performance was reviewed through spot checks, medicines competencies, supervisions and appraisals. However, some staff told us that the registered manager was not approachable at times. This meant that some staff did not always feel supported in their role.

Compliments about the care and support provided had been received. Complaints received were investigated. However, these records did not always show that the provider's procedure for recording all complaints was followed; as not all complaints received were documented. This meant that there was an increased risk that this missing information would not form part of the governance of the service to show any repeat trends, learning, and any actions taken to prevent reoccurrence.

The registered manager sought feedback about the quality of the service provided from people. There was an on-going quality monitoring process in place to identify areas of improvement needed within the service. A recent audit undertaken by the provider's quality assurance manager showed that areas of improvement required were around accurate documentation not always being available. An action place to address these concerns was in the process of being written.

Since registering with the CQC, the provider's records showed that there had been no incidents that the provider was legally obliged to notify the CQC of.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Lessons learnt and actions taken as a result of any accidents and incidents that occurred were not documented and reviewed to reduce the risk of recurrence.

Risks to people were assessed and monitored to make sure that people remained safe. There was an adequate number of staff to meet people's assessed needs and recruitment checks were in place to try to ensure that staff were of a good character.

Processes were in place to ensure that people's medication was managed safely.

Is the service effective?

Good

The service was effective.

People's needs and choices were assessed and staff supported people in line with legislation.

Staff were supported with training, spot checks, supervisions, and appraisals.

Staff worked with other organisations to deliver effective care and support. People were assisted, when needed, to have access to external healthcare services.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect when being supported by staff.

People were involved in making decisions about their care and support needs.

Staff promoted and maintained people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Not all complaints received by the service were documented.

People's end of life wishes were not recorded as a guide for staff.

People's needs were assessed and staff used this information to deliver personalised care to people that met their needs.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Not all staff felt that the registered manager was always supportive to their concerns.

Monitoring was in place to oversee the quality of the service provided and make any necessary improvements.

People were encouraged to be involved in the running of the service and give feedback on the quality of care provided.

Radis Community Care (Eden Place ECH)

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 5 February 2018 and was announced. We gave the provider 48 hours' notice of the inspection. This was so that we could be sure that staff would be available during this inspection. The inspection was carried out by one inspector.

Before the inspection we looked at all the information we held about the service. This included the provider information return (PIR) which was submitted to the Care Quality Commission on 8 December 2017. This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

We also looked at information we held about the service and the provider. Before the inspection we asked for information from a fire safety officer; representatives of a local authority contracts monitoring team and safeguarding team; and Health watch. We also sent out questionnaires to people and relatives of people who used this service to feedback on the quality of care provided. This helped us with planning this inspection.

During the inspection we spoke with four people who used the service. We also spoke with the area manager, two team leaders; and two care workers.

We looked at three people's care records and records in relation to the management of the service; accident and incident records; management of staff; and the management of people's medicines. We also looked at the provider's statement of purpose; compliments and complaints received; staff training records; and three

staff recruitment files.

Requires Improvement

Is the service safe?

Our findings

Accident and incidents that occurred at the service were not always recorded or completed correctly. For example, some of the records that staff completed had missing information including if any injury had been sustained. Records did not clarify whether there had been an investigation into the incident nor what actions had been taken to reduce the risk of recurrence, where practicable. They did not demonstrate whether the registered manager was aware of the incident as part of their oversight of the service. There was no recorded evidence that these incidents had been reviewed to see if there were any clear patterns (reasons) for the incidents or learning to reduce the risk of recurrence. For example, a pattern could be that a person fell at certain times of the day. A staff member confirmed to us that, "We have staff meetings but we don't really discuss learning from accidents or incidents. The meetings [are used to] discuss gaps in the shifts [rotas]." We spoke with the area manager about these during this inspection. The area manager told us that going forward these incident forms would be completed in full and reviewed as part of the on-going quality monitoring of the service.

Checks were carried out on new staff members to confirm that they were appropriate to work with people and of good character. Staff told us that these checks were in place before they could start work at the service. This showed us that there was a process in place to make sure that staff were deemed satisfactory and suitable to work with the people they supported. However, staff recruitment files showed that some of the checks carried out were not always recorded. For example, one staff file looked at did not record the police records check reference and some health declarations were not held in the files. This meant that staff recruitment files were not always a complete record to determine if staff were suitable to work at the service.

People's care and support plans were stored securely and contained adequate information for staff to deliver safe care. Risks to people had been identified when they first came to use the service and as staff got to know them and their individual needs. These risks were assessed to provide individual guidance for staff to support people and reduce the risk of harm. However, information for staff about people's specific health conditions was not always in place to help staff monitor people's well-being.

People had fire emergency evacuation risk assessments in place to assist them to evacuate safely in the event of a fire. Records showed and people told us that they and or their family member had signed to say they had been involved and agreed with their/ their family member's plans of care, support and risk. This showed that people were aware and involved in decisions around their care.

Staff had training on how to safeguard people from poor care and avoidable harm. They told us that they would be confident to whistle-blow. (This is a process where staff can report any poor standards of care if they ever became aware of this). Staff confirmed to us they would report any concerns they might have. A staff member said, "I would report [concerns] to the [line] manager and to the local authority safeguarding team. Another staff member told us, "I would report [concerns] to my line manager and it would be my expectation that they would report it to the local authority safeguarding team. This would be to make the appropriate arrangements and remove staff if necessary." This showed us that there was a process in place to reduce the risk of poor care practice.

Technology was used to support people to receive safe care and support when required. We saw that there were pendants (personal alarms worn around a person's wrist) in place for people, who required this additional support. These pendants were to summon staff in the event of an emergency. We also saw that people used mobility scooters to help them with their mobility for longer distances. An indoor 'scooter park' was available in the building, for people who used the service, to 'charge up' the batteries of their mobility scooters when not in use. This demonstrated to us that technology was used in the service to support people where needed.

Before the inspection the Care Quality Commission was informed that some people felt that new care staff were not always introduced to them prior to them attending their care calls and delivering care. This could make some people feel unsettled or anxious. During this inspection people told us that some staff introduced themselves to the people they would be supporting. One person said, "When the [new team leader] started she came and introduced herself." Another person told us, "New staff will introduce themselves before they start delivering care." This showed us that people's concerns about receiving new staff into their homes was reduced.

People told us that their care calls were either, 'on time' or 'mostly on time.' The area manager told us that their agreement with the local authority meant that people's care call times had a tolerance of plus or minus 30 minutes. They talked us through how they determined people's care calls times. They told us that they used a dependency tool that allocated people's care calls according to those that were most time critical down to those where people were mostly independent. This system was based on people's dependency needs.

People had mostly positive opinions over staff's timekeeping. One person told us, "[Staff] timekeeping? In the main, they are on time." Another person said, "Staff arrive on time when they help me." However, a third person told us that they would like to receive a rota that told them which staff would be supporting them the following week. We raised this with the area manager during this inspection. They told us that the team leader was undertaking a current project to look at people's care calls times and that they would look at re introducing rotas to people who would like one.

People using the service were either able to manage their prescribed medications themselves, or had been assessed as either needing a prompt (reminder) by staff as to when to take their medication, or staff administered people's medication for them. People spoken with either self-medicated or had no concerns around how staff helped them with their medication. One person confirmed to us that staff, "Prompt me, to remind me, to take my medicine…this extra assistance from staff gives [me] reassurance."

Staff told us that they had received training before they could administer people's medication and that their competency to do this was checked by a more senior staff member. Records of people's medication administration were checked each month, as part of the governance systems. These checks were to ensure that people's medication administration records were accurate. During these audits, any staff errors in recording or administration of medication, including any gaps in records, or reasons why a person refused or did not take their medication were addressed by the team leader with the staff member involved. These were addressed through a supervision meeting. This showed us that there were processes in place to make sure that people's medication was managed safely.

Staff were knowledgeable about their role in preventing the spread of infection when supporting a person with their personal care. A member of staff told us that they had enough cleaning equipment and personal protective equipment (PPE) available to use. Staff received training on how to prevent or manage any potential infections. This showed us that procedures were in place to reduce the risk of infection and cross

contamination.

Good

Is the service effective?

Our findings

External health and social care professionals worked with the registered manager, team leaders and staff to help them support and promote people's well-being in line with good practice guidance. This was reflected within people's care records. This showed us that staff worked with external health and social care professionals to try to make sure people's needs were met in line with up-to-date guidance.

People were assessed for and used equipment to promote their mobility needs. A person confirmed to us that staff offered reassurance and encouragement to them when they were using this equipment to support them. They said, "[I have] no concerns regarding moving and handling [support]. Staff know what they are doing."

Staff completed training to ensure that they had the right skills, experience and knowledge to provide the individual care and support people needed. Training included, safeguarding adults; moving and handling; dementia awareness; hydration and nutrition; complex care; Mental Capacity Act 2005 (MCA); person centred care; equality and diversity and inclusion; and fire safety. This showed us that were processes in place to make sure that staff were given training to help them provide effective care and support.

Staff told us that they were supported through spot checks, competency checks, supervisions and appraisals. They said that these were often undertaken by the team leaders and that these were a 'two-way' (joint) conversation. This, they said made them feel listened to. One staff member confirmed to us, "[I] have supervisions and spot checks with [team leader]. You can talk through concerns and feel listened to."

When new to the service staff had an induction period, where they completed the 'care certificate.' This is a nationally recognised health and social care induction training programme. This induction included training and shadowing a more experienced member of staff. A staff member told us, "[My] induction consisted of four days of training and getting to know the organisation. …I also had two shadow shifts with a more experienced staff member even though I have worked in care for many years." This was in place until staff were deemed competent and confident by the registered manager to provide care.

People could prepare and make their own meals and drinks and, cooked meals were available at lunchtime in the communal dining area of the building. People told us that staff would make them breakfast, a snack and/or a drink when they requested this additional support from staff. One person said, "Staff make me cups of coffee." Another person confirmed to us that, "I do my own meals but staff support me with a drink by the side of my bed at bed time." This showed us that staff supported people with their food and drink needs when requested.

The service worked and communicated with external organisations to ensure that the staff could meet people's needs and that a good service was provided. For example, working in conjunction with the person's local authority pre assessment review record of their care and support needs, or with representatives from the local safeguarding teams. People's care records held the contact details for all external health and social care professionals involved with each person as a prompt for staff should they need to contact them. The

area manager told us of an example of when the staff worked with other health and social care organisations when they were unable to deliver effective care and support to meet a person's increasing complex needs. The person was then moved to another care provider that could meet their needs. This showed us that staff were aware of people's changing needs and risks and when they needed to involve other agencies and services to support the person.

The building housed five re-enablement flats for people to use when they were first discharged from hospital for up to six weeks. These flats, plus the additional support from care staff enabled people well enough to be discharged from hospital, but not well enough yet to go back home, to receive some additional care and support. This was until the person built up their confidence and well-being sufficiently with the support of staff, to return back to their homes. This demonstrated to us that staff worked together with hospital staff and the local authority to support a person with their health and well-being.

The majority of people were able to attend external health care appointments independently or with support from a family member. However, people who required some additional assistance were supported by staff to help arrange health care appointments when needed. Records showed that staff had requested the assistance of paramedics to support a person following an accident or incident. GP appointments were also arranged by staff when required. One person told us, "[Staff] have got a GP to come out to me." This showed us that people's health and well-being needs were monitored and acted upon by staff.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can 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.

Staff had undertaken training in the MCA and were able to demonstrate a good understanding to us. Staff supported people with their decision making and choices. One person told us, "Staff listen to what you say. Staff do what they can to support people how they wish [to be supported]; staff let me make my own decisions." Another person said, "Staff respect my choices." A staff member told us that, "People are assumed to have [mental] capacity unless they are deemed otherwise." Another staff member said, "You assume [a person] has [mental] capacity unless otherwise stated." Where people were supported by staff in their 'best interest,' these decisions were clearly documented within people's care records. This showed that people would not have their freedom restricted in an unlawful manner.

Good

Is the service caring?

Our findings

People had positive opinions about the care and support provided by the staff. They told us that although staff supported them, staff members always continued to help promote and maintain their independence. One person said, "[Staff] are very friendly and very helpful. You can have a joke with [staff]. They are like old friends…staff are there if you need them but you have got your own place." Another person told us that, "Staff are very nice and kind."

Staff had knowledge of and respected the people they were providing care and support for. They were able to show us that they knew people's backgrounds and any preferences they had. Records guided staff on what people were able to do for themselves and what staff were to support them with. This meant that staff had knowledge on how to promote, support and maintain people's independence.

The majority of people spoken with were able to tell us they were involved in the setting up, review and agreement of their care and support plans. A person told us, "I feel involved in my care decisions." A third person said, "A staff member came out to assess me before I moved in and got to know me and my needs. I have a copy of this record. Because of this I feel involved." This showed us that staff endeavoured to involve people in the decisions about their care and support needs.

Records showed that although service users' meetings did not take place, feedback was sought from people who used the service. These quality assurance visits, encouraged people to express their views and engage with the service. Feedback from these visits were mainly positive with a few areas of improvement suggested which had been actioned or were on-going. These included improvements about the timeliness of care workers when attending a care call.

People's privacy and dignity was promoted and maintained by staff. People told us that when a staff member wanted to go into a person's flat, they knocked on their front door and announced themselves before going in. A person told us, "Staff promote my privacy and dignity – very much so. I have a preference for all female [staff] and this is supported." This demonstrated to us that staff respected and promoted people's privacy and dignity.

Requires Improvement

Is the service responsive?

Our findings

We saw that the service received compliments and thank you cards from people, their relatives and visitors of people who used the service. One compliment read, "We thank every one of you for sharing with us the care and support we have all needed to keep [named relative] at home and amongst friends to the end." Compliments were used to identify to staff what worked well.

Records documented that the service had received one complaint since they registered with the CQC. This complaint had been investigated and communication was had with the local authority safeguarding team about the reported incident. There had been efforts to resolve the complaint to the complainants' satisfaction. However, the area manager told us that they were aware of other complaints that had been received by the service. This, they said, was due to them setting up meetings with the complainants to try to resolve their concerns. This meant that complete records of complaints received were not held in line with the service's procedures. As such, information of any actions taken to resolve the concerns and reduce the risk of recurrence were not available.

Before the inspection, the CQC received information that some people did not know how to make a complaint about the service provided. During this inspection people told us that they knew how to raise a concern with staff. One person said, "I feel that the team leader, registered manager, and area manager are all approachable and would listen to any concerns if needed." Another person told us, "I am aware that I can talk to [the team leader] if I have any concerns."

Radis Community Care (Eden Place ECH) does not provide nursing care to the people it supports. The team leader told us staff were not trained in end of life care. To support people approaching the end of their life they would work with the person and their family to make sure that they met their wishes, including their preferred place of death. They also told us that they would work with external health care professionals, when it became clear that people's health condition had changed or deteriorated. This was to enable staff to support people to have the most comfortable, dignified, and pain free a death as possible.

Care records did not document people's end of life wishes, including any wish to be or not be resuscitated; cultural and religious wishes; funeral arrangements; and preferences. The team leader told us that they would contact people's relatives and the local authority in respect of these arrangements. However, this showed us that although there was a process in place for staff at the service to promote and respect people's individual end of life wishes, these wishes were not always documented as guidance for staff to refer to, when required. This created a risk that people's end of life wishes may not always be met.

Care and support plans and risk assessments recorded people's daily living needs, and care and support requirements at each care call. These had been developed in conjunction with the person, their relatives, legal representative and advocates, and in line with the local authority pre assessment review, prior to them moving into the service. These records were in place to give guidance to staff on how they could meet the person's individual needs. Reviews of these records were then carried out to make sure that these were up-to-date and reflected people's current requirements. This showed us that staff were able to get to know the

people they were supporting.

Requires Improvement

Is the service well-led?

Our findings

The Care Quality Commission (CQC) records showed that there was a registered manager in place, who was supported by an area manager, team leaders, and care staff. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. During this inspection, the registered manager was not available. The day-to-day running of the service was overseen by a team leader.

Records showed that there had been no incidents at the service that the registered manager was legally obliged to notify us of. We found that the registered manager's details had not been updated by the provider, as they needed to be, in the provider's statement of purpose and the service 'type' for example 'extra care housing' had not been indicated. A statement of purpose is a legally required document that includes a standard set of information about a provider's service. We raised this with the area manager and team leader during this inspection. The statement of purpose was updated during this inspection.

Staff told us that there was a clear expectation, by the provider, for them to deliver good quality care and support. However, staff told us that they had concerns that the registered manager did not always, listen, and respond to their concerns or suggestions. We fed this back to the area manager of the service who said that they would look into the concerns raised.

Evidence of learning as a result of the investigations into accidents, incidents and complaints was not available. Nor was any evidence that action had been taken as a result to reduce the risk of recurrence. This meant there was an increased risk that this information would not be used as an organisational oversight tool, to learn, improve, drive forward and sustain the quality of the service provided.

Quality monitoring audits were carried out by the provider's quality assurance manager. These audits looked at all areas of the service. The results of the most recent audit showed that areas of concerns found were around accurate records not always being held about people who used the service, staff and service documentation. At the time of this inspection the registered manager was in the process of writing and submitting an action plan to resolve these issues.

Staff told us that they felt supported by their team leaders and the area manager. One staff member said, "[Team leader] seems nice and competent. If you call her she will ring you back and talk you and try to resolve [your concern." Another said, "[Team leader] is doing really well. She is working hard and putting effort into getting the service up and running. [Team leader] listens and deals with things."

Questionnaires were sent out for people by the provider to engage with the service and feedback their views. Records showed that responses were positive. Any areas for improvement were noted and where possible they were being acted upon. This included reminding people who used the service of the provider's complaints policy and procedure.

The area manager and team leader told us how they worked in partnership with and shared information with key organisations to provide good care to people living at the service. This included working together with people's social workers, the local authority and the hospital discharge team.