La vie en Rose Limited

La Vie En Rose Ltd

Inspection report

18 Ashchurch Road
The Canterbury Business Centre
Tewkesbury
GL20 8BT

Tel: 01684439564

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07 October 2020

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
La Vie En Rose provides domiciliary care and support for people living in their own homes. At the time of our inspection there were 57 people who were receiving personal care. The service provided care for people with long term health care conditions, older people, people with physical disabilities, people living with dementia, people with complex care needs and people requiring end of life care. Care staff provide a service to people who need assistance with aspects of their care including mobility needs, personal hygiene and eating and drinking.

People's experience of using this service and what we found
People's individual risks were assessed and staff were given clear information on how to protect people from the risks associated with their care. Care staff had the training and experience they needed to meet people's needs.

The provider and registered manager ensured lessons were learnt when incidents occurred or where concerns were reported. They had implemented new systems to ensure people's needs and risks were regularly reviewed and any healthcare concerns were identified and appropriate action taken.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This is the first time we have inspected this service. As this is a targeted inspection the service remains unrated.

Why we inspected
We undertook this targeted inspection to follow up on concerns we had received about people's care and how the service managed people's individual risks. A decision was made for us to inspect and examine those risks.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Follow up
We will work alongside the provider to monitor the services overall progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

The service was safe.

Details are in our safe findings below.

La Vie En Rose Ltd

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of one inspector.

Service and service type
La Vie En Rose is a domiciliary care agency. It provides personal care to people living in their own homes. La Vie En Rose provided a service in Gloucestershire. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for domiciliary care. This inspection looked at people's personal care and support.

The service had a manager registered with the Care Quality Commission. The registered manager was on maternity leave at the time of the inspection, however wished to be part of this process. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We gave a short period of notice for the inspection to ensure that people and their relatives would be available to be contacted by the inspector via telephone and that the registered managers would be available during the inspection. Inspection activity started on 7 October 2020 when we visited the office and concluded on 15 October 2020.

What we did before the inspection
We reviewed all the information we had received about this service since the last inspection. This included information of concern, information provided by the provider and feedback from commissioners of the service and involved healthcare professionals.

We used all of this information to plan our inspection.

During the inspection
We spoke with the registered manager and a care manager. We reviewed a range of records. This included seven people's care and risk assessments and associated records. We reviewed a variety of records relating to the management of the service, including policy and procedures.

After the inspection
We spoke with one member of care staff and one person's relative on 13 and 15 October 2020.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. We have not made a rating of this key question, as we only looked at part of the key question we had specific concerns about.

The purpose of this inspection was to check how the service were ensuring people's care needs and risks were being assessed and how people were protected from risks associated to their care. We will assess all of the key question at the next inspection of the service.

Assessing risk, safety monitoring and management

● Risk assessments were in place for people. When risks were identified, care plans provided guidance for staff on how to reduce the risk of harm to the individual and staff. Clear guidance was in place for staff to assist the person with their food, including the consistency of the food and supporting them to pace their food to reduce the risk of choking. One member of staff spoke of the importance of assisting the person with this and their ongoing health conditions.

● People's care plans and risk assessments followed recognised best practice guidance. One person was living with epilepsy and occasionally suffered from seizures. There was a comprehensive seizure recovery plan which staff needed to follow to ensure the safety of the person. Ongoing records identified that staff followed the recovery plan to identify any changes in the person's wellbeing.

● One person was living with diabetes. Staff had been provided clear information on the support the person required and any signs they should be aware of, which included a focus on footcare. The provider had reviewed their diabetes policy following a recent concern, which detailed the action staff need to take when they supported anyone living with diabetes.

● One person required support with their nutritional needs. There was clear guidance in place from a dietician on the support staff should provide and action they should take in the person's dietary intake reduced.

● Environmental risk assessments of people's homes had been completed to ensure the safety of people receiving care and the staff who supported them. Where concerns were identified, these were raised higher to ensure appropriate support could be provided.

● Staff received training based on people's individual needs. The registered manager and care manager explained how they ensured staff had the right skills to care for people's needs and promote their health and wellbeing.

Learning lessons when things go wrong

● The provider and registered manager ensured lessons were learnt when things went wrong. Following a concern raised regarding the assessment of people's care needs and risks and the information staff received, the provider and registered manager had taken appropriate action. A key worker had been assigned to each person to review the person's plan of care on a weekly basis, identifying any changes or concerns that staff needed to be aware of. Staff also recorded any changes in people's skin integrity to ensure any concerns were identified and appropriate support was sought to meet people's needs.

● Systems were in place for staff to report and record any accidents and/or incidents. The provider and registered manager responded to these incidents to ensure people were protected from avoidable harm. For example, following staff supporting one person with an assisted fall, clear guidance had been provided to staff on the support they were unable to provide to the person due to the increased risk to their health and safety.