G P Homecare Limited

Radis Community Care (Surrey Court ECH)

Inspection report

Surrey Court
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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This was the first inspection of Surrey Court since the current provider took over the running of the service on 28 June 2017. The inspection took place over three days on 27 June, 4 and 5 July 2018 and was announced 24 hours in advance.

This service 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. 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 live in their own flats within a shared building containing 70 flats. The building also houses the offices used by the registered manager and staff.

Not everyone using Surrey Court ECH receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; such as help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

At the time of this inspection, 30 people received personal care and 22 other people received support checks from Radis staff.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People expressed concern about staffing numbers not being sufficient and the effect this had on visit times and staff morale. This was also reflected in the feedback from staff. The care schedules did not always give time for staff to move from one flat to another between providing care, so people were not assured of receiving their full allocated care time.

The provider did not have robust procedures and processes to protect people using the service from abuse or improper treatment. Staff we spoke with knew how to report safeguarding concerns. However, not all staff had received training in safeguarding.

The proper and safe management of medicines was compromised by inadequate receipt & storage arrangements.

Feedback from the majority of people we spoke with indicated that care workers had the qualities and skills to deliver effective care. However, Staff did not all receive appropriate support and training to enable them

to carry out their duties.

We received positive comments from people about the caring approach of staff. There were however also a number of comments indicating the service was not always operating in a way that treated people with respect and offered a person centred service. Staff did not feel well supported by the provider to deliver person-centred care.

The quality assurance system was not effective in identifying issues within the service. There had been a lack of effective oversight by, and feedback from, the provider. Audit trails were not complete. The culture within the service did not support the delivery of high quality care. People did not always feel listened to by the provider and that their concerns were responded to effectively. CQC was not always notified when required of incidents.

A system was in place to keep track of and record relevant checks that had been completed for staff who worked in the service.

People's consent was sought to confirm they agreed with the care and support provided. The provider had policies and procedures for when people were not able to make decisions about their care or support.

Where people required support in relation to preparing food and drink this was recorded within their care plans.

People's care records showed relevant health and social care professionals were involved with people's care when required.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Health and Social Care Act 2008 (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff were not always deployed in sufficient numbers to meet the needs of people using the service at all times. People were not assured of receiving their full allocated care time.

Not all staff had received training in safeguarding people.

The proper and safe management of medicines was compromised by inadequate receipt & storage arrangements.

A system was in place to keep track of and record relevant checks that had been completed for staff who worked in the service.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not all receive appropriate support and training to enable them to carry out their duties.

People's consent was sought to confirm they agreed with the care and support provided. The provider had policies and procedures for when people were not able to make decisions about their care or support.

People received support in relation to preparing food and drink as recorded within their care plans.

Health and social care professionals were involved with people's care when required.

Is the service caring?

Requires Improvement

The service was not always caring.

People using the service were not always treated with dignity and respect.

Staff did not feel well supported by the provider to deliver

person-centred care.

The majority of staff treated people with care and compassion.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always feel listened to by the provider and that their concerns were responded to effectively.

Each person had an assessment of their needs containing information to enable staff to provide personalised care in line with each individual's needs and preferences.

Is the service well-led?

Requires Improvement

The service was not well led.

The culture within the service did not support the delivery of high quality care.

The quality assurance system was not effective in identifying issues within the service.

The registered manager was not always aware of her responsibilities.
CQC was not always notified when required of incidents.

Radis Community Care (Surrey Court 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 27 June, 4 July and 5 July 2018 and was announced. We gave the service 24 hours' notice of the inspection visit because the service operates an extra care housing service to people in their own tenancies. We needed to be sure that a member of staff would be there to meet us.

The inspection was carried out by one inspector.

Before the inspection, we reviewed the information that we held about the service including any feedback and notifications. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with nine people who used the service. We spoke with the registered manager, a team leader and six members of the care staff. We looked at a range of documents including care records and risk assessments for five people, staff recruitment and training records. We also looked at information regarding the provider's arrangements for monitoring the quality and safety of the service provided.

Requires Improvement

Is the service safe?

Our findings

Overall people's feedback was positive in relation to staff caring. All however expressed concern about staffing numbers not being sufficient and the effect this had on visit times and staff morale. Comments included "Too many nights when there is only one member of staff on duty"; "Weekends are awful" and "They (staff) are a bit stressed, a lot on their plate, particularly in the evenings". Also, "Staff try to do what they're supposed to do, but they're so rushed, it's in and out". This was also reflected in the feedback from staff.

A person said a care worker had told them they had another care call booked at the same time. We looked at the lists of scheduled care calls and saw that the end time of one person's care coincided with the start time of another person's. The majority of the lists did not give time for staff to move from one flat to another between visits. The registered manager said contracts with the care commissioner gave half an hour leeway on scheduled visit times, and this had been explained by a representative of the commissioning body in a meeting with tenants. The providers printed customer guide did not contain information about this agreement, which would inform people about what to expect.

Another person said care workers were "Forever late coming in". They said their early morning support was usually on time, but the personal care they were meant to receive at 1pm frequently did not arrive until 2pm. They said "Staff don't stay. They don't like the way they're spoken to, or the way the shifts are changed around". Another person commented "A lot of them go sick. I think they're genuinely not well. The weekends are particularly bad".

The schedule lists did not give time for handovers between shifts. The morning calls started at 7am when the morning shift arrived for work. There was a note in the staff room from a senior manager informing staff that 'runs start at 7am and all staff to be on the floor by 7am'.

Night cover was felt to be an issue by staff and people using the service, as there was one care worker commissioned for each service per night and a 'floating' care worker, based at Surrey Court, who worked between services. This frequently left the service with one care worker at night, which the registered manager said did not feel safe. However, the provider stated that the 'floating' care worker was funded to be shared across all four services.

At the time of the inspection there were five people receiving care who would need two staff to provide care safely. If people required care at night they could not be assured that there would be the two staff to provide it. In exceptional circumstances, such as a person being unwell, the service would have to rely on emergency services as there was not enough flexibility in the rota of staff available. Staff were also required to cover shifts, often at short notice, at other extra care services run by the provider. There were reported difficulties recruiting staff. Advertisements for care workers had been put out.

Staff told us "We run short staffed all the time". Staff sometimes worked 15 hour shifts from 7am until 10pm. They said one care worker often worked 80 – 90 hours per week. This care worker was about to go on leave.

The registered manager said she sometimes assisted the staff by doing care visits. This would not be reflected on the rota. The staff rota folder was not available when we asked for it. We were told the area manager may have it.

The registered manager acknowledged the service was short staffed. If the other services were short staffed there was a knock-on effect. During the inspection, there were two shifts for the coming Sunday that needed to be covered in the service, despite one care worker doing a 15 hour shift. The registered manager also received an email from one of the other services informing them that they had five shifts that week and nine shifts the next week that needed to be covered.

Following the inspection visit we continued to receive concerns about staff numbers and deployment. We raised this with the provider and sought specific assurances about staffing arrangements for the weekend and following week.

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

Staff we spoke with knew how to report safeguarding concerns. The majority of these staff were experienced staff. However, we found that not all staff had received training in safeguarding. The registered manager told us there had been an allegation of a member of staff verbally abusing a tenant and using threatening behaviour. Records relating to the incident included statements from other staff and a note about a discussion between the member of staff and a team leader. Although the service has systems and processes in place to safeguard people from abuse, these were not being used effectively. There was no outcome recorded and it was not evident that the local authority safeguarding team had been informed.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before this inspection we had received information about possible unsafe medicines management.

On the first day of the inspection we saw a large open box containing people's medicines was unattended by the door inside the staff room, which was not locked. Staff told us they were unable to access the office in the absence of a manager or team leader, to check the medicines in. They confirmed that the staff room door was sometimes left on the latch as staff would come and go and that the medicines could have been there since the day before.. When we pointed out the medicines to staff they put them in a cupboard in the staff room.

A tenant said there had recently been an incident when "It took from Friday to Sunday" to get the medicines they needed, which were in the locked office. They received these when the team leader came in on the Sunday.

The registered manager told us there was an issue with the pharmacy delivering medicines later in the day, when the registered manager and team leader were not on site to log the medicines in. This meant medicines were left overnight in the staff room. The registered manager said they were looking at using another pharmacy. Staff might also take medicines to a person's flat that had not been checked in and signed for.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that supporting people with their medicines mostly involved prompting.

We also received concerns about unsafe infection control practices in that bags of soiled pads were left outside of the office. On the day of our inspection we did not see any bags of soiled pads or any concerns about infection control. Staff were using appropriate personal protection equipment.

A system was in place to keep track of and record relevant checks that had been completed for staff who worked in the service. We looked at the records of three staff. These included evidence of employment histories, previous employer references, and satisfactory Disclosure and Barring Service (DBS) clearance. DBS checks enable employers to make safer recruitment decisions by identifying candidates who may be unsuitable to work in care services.

There was a fire procedure on the staff room wall attached to a 'read and sign' sheet for staff. Out of 22 listed staff, 11 had signed, the last signatures having been recorded in April and May 2018. There was also a list of names of people and whether or not they were able to evacuate the premises in the event of a fire. The list was not dated so it was not clear if it was an up to date and accurate record.

Requires Improvement

Is the service effective?

Our findings

Feedback from the majority of people we spoke with indicated that care workers had the qualities and skills to deliver effective care.

The provider employed a training person who came to services to train staff. Training certificates on a staff member's records included moving and handling, reporting and recording, promoting continence, stoma care, and day one of the provider's core induction. There was also a medicines record used for training purposes. Another staff member's records contained certificates of training in moving and handling, reporting and recording, and medicines administration. There was no record on file of any training attended since June 2017.

The registered manager told us the trainer had been coming in to provide the standard induction training in moving and handling and medicines. Due to priority being given to recruitment and induction of new staff, further training for staff had not been moving forward.

Staff said the trainer was very good. They confirmed they had received training in moving and handling, reporting and recording, and medicines administration. One care worker, who had been employed for over a year, told us they had only received the introduction, moving and handling and medicines administration. Staff told us they had not had safeguarding or first aid training from the current provider. They said catheter training had not been delivered as planned.

New staff were supported to complete an induction programme before working on their own. Staff told us all or the majority of new staff did 'shadow' shifts at Surrey Court, but then went to work at other extra care services, sometimes with people with increased complex needs such as those living with dementia. One care workers record of shadowing induction was not dated, so did not show the period over which this took place.

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

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. Care plans indicated that people were able to make their own decisions or with support from relatives. People's consent was sought to confirm they agreed with the care and support provided. The provider had policies and procedures for when people were not able to make decisions about their care or support.

Staff were aware that it was part of their role to monitor people's wellbeing and report any concerns about a person's mental capacity to senior staff and external agencies, so that an appropriate assessment could

take place.

Where people required support in relation to preparing food and drink this was recorded within their care plans.

People's care records showed relevant health and social care professionals were involved with people's care when required.

Requires Improvement

Is the service caring?

Our findings

We received a lot of positive comments from people about the caring approach of staff. There were however also a number of comments indicating the service was not always operating in a way that treated people with respect and offered a person centred service. Staff did not feel well supported by the provider to deliver person-centred care.

One person told us "The care workers are wonderful, but their hands are tied. The management don't care about the staff, it's as if they don't matter". They said staff were "talked down to, talked at" and told "If you don't like it you can go somewhere else. The manager can't do anything, she has to do as she's told. She is inundated with all the minor issues".

The feedback we received from people did not indicate that all staff treated them at all times with respect. A person said one care worker "Swears at residents. Some won't let her in". This was reflected by another person saying one care worker "Swears a lot". We spoke with the registered manager about this issue and she said she would follow it up. Another person told us there was a member of staff "I don't want in my flat, moaning about other staff". This person also told us the member of staff had opened the door to their shower and asked to speak with the care worker supporting them; "I said no, she's helping me, please close the door".

Another person told us when they had been unwell and in bed for a number of days "No-one came from the office in between (scheduled) morning and night visits to see if I was alright. They could've popped their head round the door".

The feedback we received did not always evidence a person-centred approach to people's care and support. A person said "You don't get asked, it just gets done". This person had requested a change to the timing of their support at bedtime, as this was currently the same as it had been with another agency when the person was unwell and was early in the evening. They told us that when they had first raised this with the manager they were told 'I will see what I can do'. After a month the person went back to the manager as they had not been given an outcome to their request. They said they were told the timing could not be changed. Following the first day of our inspection, the person raised the matter again and their evening support was scheduled for a later time that met their wishes.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff members we spoke with were clear about treating people with dignity and respect. They were knowledgeable about how to respond to people's needs and respected the privacy of their flats. People's records included information about their personal circumstances and how they wished to be supported.

Comments from people also included that care workers were "All friendly" and "We get along, have a good laugh sometimes"; and that the majority of staff were "Caring and kind, when not in a mad rush to catch up".

One person said the manager was "Very helpful and listens to anything you say". They told us "When I've required help it's always been there". Another person said "They're a pretty good crowd. They're a bit stressed, a lot on their plate, particularly in the evenings". Care workers were "All very courteous. If there is anything wrong they come as soon as they can". They told us they thought the manager was approachable and would listen, though they had not had reason to raise any concerns. Another person said "I'm happy here but I would like a little more support".

We saw a letter from a person's relative, thanking staff for the care and support, which had helped avoid their relative going into hospital. Another letter from a person's family thanked staff for the care they gave to the person before they had passed away. A letter from a tenant thanked staff for helping them to sort out a housing issue. The registered manager had arranged the funeral for one person as the person's spouse, also a tenant, had not been able to manage this at the time.

The registered manager told us they and other staff had personally funded additional activities, entertainment, food and decorations within the service. The provider told us there is an activities budget the manager can draw on by making a request for an item to be purchased via the head office finance team. The provider had purchased some activities equipment as part of the service contract and part of the role of staff was to implement the activities.

Requires Improvement

Is the service responsive?

Our findings

People did not always feel listened to by the provider and that their concerns were responded to effectively. Some people felt able to raise their concerns with operational management but there were mixed views as to whether their concerns were addressed effectively. There was a complaints procedure. Some tenants felt that concerns or issues they raised were not dealt with or responded to properly. A person told us "When I've said to staff I want to speak with the manager, it's passed on but nothing happens". They said when they complained they were told the service was not short staffed; "It achieved nothing". The registered manager was unable to provide us with any records of complaints or concerns raised.

We recommend that the complaint processes are reviewed in line with best practice.

People did not always think the service was responsive to changes in people's needs. A person spoke of their concerns regarding the increased needs of some people now living at Surrey Court and the impact this had on the ability of staff to meet everyone's needs. They said people "Can wait a long time" for staff to respond to calls. They told us they were happy with the way staff provided care and support, but they were "Concerned about the strain on staffing". They said they had not noticed staffing levels increasing in line with people's needs.

During the inspection the registered manager contacted a service commissioner to discuss a person's increased care needs. The registered manager told us a 'variation to care' record was completed for any requests for additional funding for care.

People's care files included sections about their personal histories, religion, culture and spiritual identity, health needs, medicines, communication, emotional needs, personal care, nutrition and hydration requirements, personal safety, social and recreational activity. Each person had an assessment of their needs containing detailed information about their morning, lunch, afternoon and evening routines, as appropriate, and the support they required with tasks such as bathing, dressing, medicines and meal preparation. The information would enable staff to provide personalised care in line with each individual's needs and preferences. An example of a personalised approach was staff used their mobile phones to translate during conversations with a person who did not speak English.

Risk assessments in relation to aspects of care such as mobility and medicines were recorded with the method of support described. For example, a person not currently able to walk following an operation required two staff to support them with sitting and standing and one care worker to assist them with a shower. However some risks assessments were more generic in nature and were not very detailed. The registered manager said they were working at improving these as part of the change to the provider's format.

When care plans were reviewed within the service this was recorded. While a person's review records were not very detailed they did show they were involved in reviewing their care.

Requires Improvement

Is the service well-led?

Our findings

The culture within the service did not support the delivery of high quality care. People did not feel listened to and any concerns they raised addressed. Radis Community Care had taken over the service from another provider in June 2017.

Tenants and staff did not feel involved or listened to by senior management. There had been no feedback received from head office in relation to a tenant's quality survey. The registered manager told us the provider had carried out a customer satisfaction survey. Questionnaires had been sent to people and their responses returned to the head office. The registered manager had not received any feedback or outcome of the survey. There had not been a staff survey to date and since taking over the provider had not arranged to speak with the staff team.

The quality assurance system was not effective in identifying issues within the service. There had been a lack of effective oversight by, and feedback from, the provider. Audit trails were not complete.

The registered manager told us checks and audits of daily care records and medicine charts were just starting to be implemented. There were plans to start weekly medicines administration record (MAR) and care file audits at a team leader meeting the next week. This had not been happening to date because they had been busy updating care files to the provider format. The provider subsequently informed us that some records had been audited but had not been filed.

The registered manager told us she sent a quality report form to the area manager. This format relied on the information being logged onto another system in order for the registered manager to pull off reports, which she was currently unable to do. The area manager had put this system in place in the last two months.

The area manager had contract monitoring meetings with service commissioners and would ask the registered manager by phone for information to feedback.

The provider had a system of compliance checks. Shortly after the service commenced the previous year, the provider's representative had checked staff and tenant records, health and safety information and insurance certificates. The registered manager said another member of the senior management team had frequently been on site for the first six months and came again three months later, to check records and files. There were no records of compliance checks or outcomes held on site.

During the inspection the registered manager obtained copies from the head office of quality assurance reports for February / March and July 2017, which had focused on assessing the quality of staff personnel files and learning and development records, following the transfer of the service to Radis Community Care. The reports identified various levels of good practice and non-compliance. There was no further report after July 2017. The provider informed us that an annual quality assurance visit was due. The provider was aware of breaches of regulations identified under the previous provider. The provider had drawn up an action plan based on improving areas of non-compliance identified under the previous provider but a completed

version with dates of actions taken could not be located at the time of the inspection. The registered manager had drawn up her own action plan for the service, which she said had been seen by the area manager, however she did not know if this action plan had been approved.

We asked the registered manager how the times of care visits were monitored. They told us there was no specific record available for missed or late visits. The visit times were recorded in each tenant's care notes and "People would need to complain if there was a persistent issue".

The lack of an effective system of monitoring visit times had been an issue at other services run by the provider. Therefore, people's safety could not be assured because the provider had not ensured lessons were learnt following inspections at other services run by the provider.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not clear when the registered manager was working and she was not listed on the rota. The registered manager was also tasked with supporting the development of a new service. There was a reported lack of management time to keep up with administrative tasks and support for administrative tasks was unclear.

The registered manager was not always aware of her responsibilities. CQC had not received the requested provider information return (PIR). This 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. In addition, the registered manager had not notified CQC when required of one incident so that where needed, CQC could take follow-up action. This incident involved a safeguarding allegation that CQC should have been notified of.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

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 18 Registration Regulations 2009 Notifications of other incidents The registered person had not always notified CQC when required of specific incidents affecting the health, safety and welfare of people using the service. Regulation 18(2)

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People using the service were not always treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The proper and safe management of medicines was compromised by inadequate receipt & storage arrangements. Regulation 12(2)(g)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have robust procedures and processes to protect people using the service from abuse or improper treatment while receiving care and support. Regulation 13(1)(2)(3)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not in place and robustly operated to assess, monitor and improve the quality and safety of the service. Regulation 17(1)(2)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not always deployed to meet the needs of people using the service at all times. Regulation 18(1) Staff did not all receive appropriate support and training to enable them to carry out their duties. Regulation 18(2)(a)