Mr Robert Malcolm Burt

RmB Healthcare (Unit 1035)

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 22 May 2017, and was announced. RmB Healthcare (Unit 1035) is a domiciliary care service (DCS). DCS provides support and personal care to people within their homes. This may include specific hours to help promote a person's independence and well-being. At the time of the inspection 6 people using the service were designated support with personal care.

The provider was managing the service at the point of inspection. The provider is a person who has registered with the Care Quality Commission to run the service and is a 'registered person'. 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 were not kept safe. Risks were not assessed to minimise the possibility of a harm. This meant that staff were not given guidance and may not know how to manage a risk should one occur. The provider did not have systems in place to ensure sufficient suitably qualified staff were employed to work with people. References, gaps in employment history and photographic ID was missing from staff files, including that of the provider.

People received care and support from staff who did not have the necessary skills and knowledge to care for them. The provider did not invest in training. Inductions involved staff reading people's files and shadowing existing staff.
Staff were not appropriately supervised or supported. Communication within the service was poor, with no team meetings taking place or adequate information sharing occurring, except those related to rota'd shifts. The provider had bought staff mobiles, so that any changes to shift patterns could be passed over.

Whilst documents on how to support people were not in place, in files, people spoke positively of the support they received. We were told that staff were caring, and ensured people's dignity was preserved at all times. People were encouraged to maintain their independence, with staff supporting should this be required.

The service was not well-led. The provider did not have adequate systems in place to monitor and maintain an overview of the service. Staff retention was a further issue.

We found a number of breaches in regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff were not provided with appropriate training, competency assessment and performance appraisals as was necessary for them to carry out the duties they were employed to perform. The provider had not established an effective system that ensured their compliance with the fundamental standards. The fundamental standards are regulations 8 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

special measures will be kept under review and, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Appropriate recruitment processes had not been employed to establish the suitability of staff working at the service.

Risks had not been appropriately assessed.

The internal safeguarding policy was not followed, with two staff not being training in safeguarding, and the remainder of the staff requiring refresher courses.

Is the service effective?

Requires Improvement

The service was not effective.

Staff were not appropriately trained to carry out their duties effectively.

Staff were not supervised or appraised.

People felt that they received adequate support with eating and drinking.

Is the service caring?

Requires Improvement

The service was not always caring. There was no clear evidence that care was provided in line with people's needs.

People reported that they were respected and had their privacy and dignity maintained at all times.

Where people were independent with tasks, they were given the opportunity to continue do things for themselves, with staff remaining present should help be needed.

Relatives felt that the service was additionally supportive and caring towards their needs, and not only peoples.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Documented care plans were not accurate or reflective of people's needs. With little evidence of reviews taking place.

The provider did not have a documented complaints procedure, highlighting the process which was worked through when dealing with a concern.

Is the service well-led?

Inadequate

The service was not well-led.

The provider could not evidence that he had the necessary qualifications, training, skills required by the provider when operating a service.

Feedback surveys from people were not analysed or assessed and no action was taken as a result of people's views.

There were no audits completed by the provider to enable them to identify any issues related to the operation of the service.

RmB Healthcare (Unit 1035)

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. 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 22 May 2017 and was unannounced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the office at the time of the inspection.

As part of the inspection process the local authority were contacted to obtain feedback from them in relation to the service. We referred to previous inspection reports and notifications. Notifications are sent to the Care Quality Commission by the provider to advise us of any significant events related to the service, which they are required to tell us about by law. As part of the inspection process we also look at the Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, what the service does well and improvements they plan to make, in relation to the five domains we inspect. We had received the PIR for RmB Healthcare (Unit 1035), therefore were able to consider the manager's views on the service prior to visiting.

During the inspection we were unable to speak to any staff. We had called all four staff on several occasions and requested call backs. Unfortunately, no staff returned our calls, irrespective of the request going through the provider. All information was therefore gathered from the provider during the course of the inspection. In addition we spoke with three people who use the service and three relatives of people who were authorised to speak with us on their behalf. We also spoke with two professionals from the local authority.

Records related to people's support were seen for all six people who use the service. In addition, we looked at a sample of records relating to the management of the service. For example staff recruitment of four of the staff team, including the provider were reviewed.

Inadequate

Is the service safe?

Our findings

The people we spoke with stated that they felt safe with the staff that attended their calls. One person said "The girls are excellent. They really look after me and [provider] will check up on me every day. They really do make me feel safe". A relative stated, "Oh definitely [relative name] is safe with the staff."

People were not kept safe by the recruitment procedures implemented by the provider. At the time of the inspection two staff were employed on zero hour contracts, whilst a further two staff were being taken through the induction process, shadowing existing staff. In addition to the staff team of four, the provider completed house calls to people. We requested to see all the staff files and were given three in addition to the provider's file. The provider did not have one of the staff files, and was unsure where this was, stating it may possibly be at his home. We found that the recruitment procedures were not robust and heightened the risk of unsuitable staff being recruited. We found that gaps in employment were not explained and references were not from the last employment. Identification photographs of staff were not on files and the disclosure and barring service (DBS) checks were carried forward for some people from their last place of employment, and had not been completed by the provider. A DBS enables potential employers to determine whether an applicant has any criminal convictions that may prevent them from working with vulnerable people. Checks were not obtained or verified prior to employment being offered. This put people at potential risk of having staff work with them that may not be suitable to carry out their duties. In addition, of the two staff who had been working at the service, one staff file was unavailable for us to see, and the other staff member had left employment in summer 2016. Upon her returning to work for RmB Healthcare (1035), the file had been pulled out of archive and reinstated. No further checks had been completed in relation to where she had worked during her break from RmB Healthcare (1035) employment, new references had not been sought – although it was known that she had worked in social care and the old DBS was being used. We asked the provider to explain why he had not completed all the necessary checks and were told he recognised he had made a mistake. We checked the providers employment file and found that it contained no employment history, no references, no health declaration, no ID.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which stipulates that persons employed for the purpose of carrying out a regulated activity must meet specific requirements, which are further outlined in detail in Schedule 3.

The service offered to people was not always safe. Risk assessments are documents that identify known risks and actions to be taken in response to the risk. They are designed to keep people as safe as possible by minimising the potential of the risk. These documents should be kept up to date, so that staff are aware of how to reduce the risk, or should a risk be identified, what actions to take as people's needs continually change. We found that people's files contained environmental risk assessments, however specific risk assessments had not been completed. For example, we were told by the provider that one person had complex behavioural issues that included the person becoming verbally and physically challenging towards others at times. We asked the provider to show us where within the person's file this was documented in order to guide staff to provide safe and appropriate support for the person. We were told it was not documented, as the behaviour was "tricky". In another file we found that a person required 2:1 support with

mobility due to health issues. There was no information for staff of how to support, monitor and care for the person to minimise the risk of injury to the person or staff during assistance. Where a risk to a person or staff has been identified, risk assessments are needed to ensure staff had adequate guidance to provide support in a safe and appropriate way. It was further unclear if any harm had occurred to people as the service was poor at maintaining records.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which states that care and treatment must be provided in a safe way by mitigating risk.

The provider's policy and procedure for safeguarding stated that this training course needed to be updated annually. This was to ensure staff had the latest knowledge on how to keep people safe from abuse. We found that none of the staff had received training in this area, in the last 12 months. This also included the provider, whose training had expired almost two years ago. The provider further told us that he would not be putting his two new staff (currently on induction), through the training. We queried the reason for this, specifically given this was stipulated as an important training course for all staff according to the company policy. The provider stated this was linked to staff retention, and financial issues associated with paying for training. The provider did not have a clear understanding of safeguarding and whistleblowing. We discussed both protocols with the provider, providing scenarios within which either would be appropriate. The provider was unable to fully understand reportable incidents under safeguarding, as he could not identify the different types of abuse that were reportable. However we could not find any evidence of there having been any safeguarding that required to be reported. We were unable to establish whether staff understood the principles of safeguarding, as we had been unsuccessful in speaking with them.

Whilst the staff did not administer medicines, they were involved in prompting people with this task. The initial assessment detailed the times at which staff needed to attend calls to prompt people. The service were not involved in following any missed medicines up with medical practitioners, as this was not a part of their remit. It was unclear what the protocol was when a person refused their prompt. For example, if this was notified to anyone, or whether this was documented to evidence a dose had not been taken.

There were no systems in place to monitor incidents and accidents. This meant that the service were unable to note trends occurring in order to prevent similar occurrences in the future should an incident occur. The manager reported that there had been no accidents, but did advise of a person who could be challenging towards staff. We queried whether there had been any incidents specifically in relation to this person. We were unable to ascertain this fact. We suggested that if there had been incidents if there was a document to help note trends, similar incidents could be prevented.

We requested the provider send us a copy of their business contingency plan in the case of an emergency, as this was not available for us to see on the day of the inspection. Unfortunately this was not sent to us. This meant that we were not reassured that the provider would be able to continue to provide a service to people and keep them safe in an emergency situation. For example, if the staff team were affected by diarrhoea and vomiting the contingency plan should outline what action would need to be taken, i.e. use of bank staff or another local agency.

Requires Improvement

Is the service effective?

Our findings

People were supported by a staff team that had not received effective training to help support them with their role. Staff did not have the correct training to keep people safe from risk. Staff files indicated that training was delivered ad hoc. The provider did not keep a record of which training staff had completed, or when this was due to expire. We discussed this with the provider and were told that he recognised this was an issue, however as staff retention remained an issue, he felt unable to invest in this at present. The two staff on induction were not receiving any training, but were gaining hands on experience shadowing staff whilst reading people's files and meeting with people. We were unable to determine if staff had come with existing training from previous employment, as records were not kept up to date to provide this information. One person required 2:1 support with personal care, using a hoist. It was unclear if staff had the necessary training to assist using this equipment. We raised this as a concern. In addition we found that the provider's training had expired two years ago, and he had not invested in this either. In the inspection of April 2014, training had been raised as an issue of concern. The provider subsequently forwarded us an action plan that was inspected against in June 2014. We found that whilst the provider had asserted he would ensure all staff were trained in and had completed their Skills for Care, this guidance had not been followed in the June 2014 inspection. At the inspection of April 2015, this regulation had been met and staff had completed their training.

Staff files indicated that staff had not received regular supervisions and appraisals. Records of the three staff files we saw highlighted none had received supervisions. We discussed the need to regularly supervise staff to ensure they were working in line with best practice, and provide staff with an opportunity to raise any issues. The provider recognised that this was not being completed and that staff may as a result feel as though they were not supported within their role, however we were unable to speak with staff about this.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which stipulates that staff should be competent, skilled and experienced to carry out the tasks needed, with appropriate support and training.

We asked the provider what methods of communication were employed to keep staff abreast of any operational changes to the service. For example, whether the provider held team meetings, and the frequency of these. We were told that the provider did not have sufficient time to arrange these, as he was a member of the staff team. Information was circulated during a double up call (when two people need to attend to one person). Information that was urgent would be given to staff by phone. RmB Healthcare (Unit 1035) had provided all staff with company mobile phones. This ensured that the provider was able make contact with staff as and when required. However, as we were unable to speak with staff, this could not be confirmed.

Staff had not received training in the Mental Capacity Act (MCA). 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. This is authorised via the court of protection, as the person is residing within their own home. At present the service was not providing support to anyone who was under DoLS.

People we spoke with said that staff sought consent before completing personal care. They were described as being "very good, always ask". A relative reported that the staff always asked one person if they wanted assistance with personal care, prior to helping, and were always told "no". The relative recognised that it was essential for staff to seek permission prior to engaging in a personal task, however reported that as a result the person would often not bathe frequently.

People reported that staff appropriately supported and assisted with food and hydration, ensuring they attended the call at the correct time, so that people would not go hungry.

Requires Improvement

Is the service caring?

Our findings

We could not find documented evidence of people or their representatives being involved in the devising and reviewing of care plans. The lack of documentation meant that any new member of staff may not be aware of how to deliver the support and care, in line with the person's preference. We found that the provider had not maintained accurate records related to people, for concerns of breaching confidentiality, as files were also kept in people's homes. We spoke with the provider, discussing ways that information pertinent to the person's care, could be available in the office file if there were concerns around confidentiality or of upsetting people. The feedback from people and their representatives suggested that care was delivered in line with preference. As people became familiar with staff they were able to prompt them to changes and guide them in any new areas of support. One relative stated, "the fact that the service is so small, means that my [relative] always gets help from the same girls. She's built a relationship with them now, she honestly trusts them."

The documents held in people's files did not evidence or illustrate that people's rights; equality; culture had been taken into consideration or evaluated. This therefore had the potential of people's rights to receiving care the way they wished to not being met, as these points may not have been considered at the time of the initial assessment. We do not have evidence to show this was having a negative impact on people.

People and their relatives reported that the service was caring. We were told that staff spent time with people and talked to them in a kind and considerate manner. For one person, the provider had arranged daily welfare checks to reassure the relative that the person was safe, and had ended their day pleasantly. The relative told us "he [provider] is caring towards me too, the work extends out to the family."

Staff were described as being respectful and always striving to maintain people's dignity when assisting with personal care. We were told that staff always, "draw the curtains in the bedroom, and ask before helping me". This point was resonated by another person who reported that staff were considerate of their feelings. If they did not want to have personal care when staff attended, then this was not forced upon them. One relative told us that the person was "unwilling to accept help" and felt that they were "still very independent". They told us that staff would respect the person's choice, however, remained with the person for the duration of the call in case they required support.

People told us that staff would explain or talk through a task prior to commencing it. This gave them a feeling of being involved in the task and allowed them to build a relationship with the staff member assisting.

Requires Improvement

Is the service responsive?

Our findings

The service was not responsive to people's needs. We found that whilst each person's file contained an initial assessment, this had not always been completed prior to care and support commencing. For example for one person we noted that the initial assessment was dated 28 March 2017. Upon checking the daily logs we noted that care commenced on 1 March 2017. We queried how staff knew what support to provide to the person, and whether the person had actually been consulted prior to the support package being set up. The provider was unclear of when the support actually commenced, and further was unclear of why the initial assessment had been completed four weeks after support had commenced. We checked the person's file for a local authority care plan and were unable to locate this. This therefore suggested that staff were not provided any background information on the person prior to working with them, although the person was verbal, their health related issued meant at times they were unable to communicate their support needs. In another person's file, we noted that the initial assessment did not indicate some of the behavioural issues that may cause complexities when working with the person. We asked the provider why such vital information was missing, and were told "because the person is tricky". The provider did not have a care plan for this person that incorporated their choice and wishes, specifically given that this person was at times unable to communicate this. We found that all people's care plans were inaccurate in that they stated that the person did not need any support with personal care. We spoke with the manager about the inaccuracies who stated this was an oversight on his part.

The files for people did not contain sufficient information informing staff how to support people. For example, in one person's file the care plan linked to the initial assessment stated, support with personal care, however did not detail how this needed to be done, and what this entailed. Whilst the person was able to verbally communicate therefore could advise how they wished to be supported, some of their behaviours meant that at times they were unable to advise staff at the point when a person was becoming agitated or upset how they needed to be supported. Furthermore the last page of the initial assessment highlighted the person did not require personal care, and was solely independent in this area. We showed the provider the inaccuracies in the document, and were told that the person did not always agree to being supported with personal care, However there was no guidance for staff on what to do should care be refused. It was unclear if the wishes if the person had been sought and also unclear if the care and support provided by RmB Healthcare (Unit 1035) was reflective of the needs of the people.

People told us that they were very happy with the service and had very little to complain about. If any issues were to arise, they would raise these directly with the provider. We asked the provider to show us evidence of how complaints or concerns were being managed. The provider told us that the service very rarely received any complaints or concerns, therefore had not created a system to record, investigate or monitor these. The provider then stated that any concerns, as they arose were resolved and recorded in people's files. We asked to see examples of this, however none were produced.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which states that complaints must be investigated and proportionate action must be taken.

Inadequate

Is the service well-led?

Our findings

We found that the service did not have good management and leadership. The sole provider managed both the service and the staff team. In the April 2014 inspection, we raised an issue regarding the provider's suitability to operate the service, specifically in relation to qualifications and knowledge. The provider assured us in his May 2014 action plan that he would enrol on an appropriate course. We received an email from the provider within which he advised that he would have completed all necessary qualifications by 2016. In our inspection of April 2015 the provider told us that he had commenced college and was focusing on three modules. At this inspection the provider confirmed that he had not completed any of the modules. Furthermore they had not refreshed their own training since June 2015.This meant that the provider had failed to demonstrate they had achieved a relevant level of qualification for their role.

The provider failed to evidence to us that he was of good character. There were no references from prior employment, no evidence in line with the company policy of annual DBS checks, the last having been completed in 2012, or any information available on the provider's employment history or professional qualifications. We raised this as a concern with the provider and were told that he had not had sufficient time to collate this information. The provider failed to supply to Commission, or arrange for the availability of, information relating to themselves specified in schedule 3 during the inspection. This was subsequently requested post inspection, whilst some information was provided, this was not in full.

The provider failed to meet the regulations required when providing a service He appeared to have limited understanding of the consequences and risks that this posed. This was a breach of Regulation 4 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which specifically looks at the requirements of an individual being suitable to carry out the regulated activity.

The registered manager did not have accurate, complete records for each service user, that were appropriately checked, updated and cross referenced. For example when we looked at one person's brief history on their initial assessment and saw that it stated the person required 90 minutes support, on the second page it read 60 minutes support. The final page again read 60 minutes support, and was signed off by the provider. We queried what the duration of support was and were told it was 90 minutes. A similar error was repeated in another person's file. Support was indicated for the weekend three times a day with one evening welfare check. When we spoke with the person they advised that they only received two calls on one day plus the welfare check. The provider was unable to give a reason for the inaccurate details contained with the document. The inaccuracy carried a risk in relation to staff not being able to provide the support required to the person. For example, the additional time was given to allow staff to support a person with their weekly bath. If sufficient time was not available then it was possible that the person may have been unable to have had their weekly bath.

We asked the provider whether any audits were completed to ensure documents pertaining to staff or people were up to date, and were told that there were not. We queried how the provider could ensure that people' needs were being met and that these were in line with regulations. The provider was unable to provide a response. We sought to find evidence of any audits within the registered location. We were unable

to find examples of any audits or checks and the provider did not provide these to us following the inspection.

We asked the provider if he had sent quality assurance questionnaires to people for feedback on how they felt the service was delivering care and how they could improve. The provider told us that he had done this, however there was no evidence to illustrate this. The provider had not assessed the feedback and no action plan had been generated to see how improvements to the service could be made and no actins had been taken. Staff and professionals were not asked to provide feedback to the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which states that systems need to be in place to assess, monitor, improve the quality of the service.

We were unable to find evidence of the culture of the service, and how approachable and open management was, due to being unable to speak with staff. This meant that there we were not reassured that the ethos and value of the service was projected in support and care by staff.