Rainbow Medical Services Ltd

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 16 August 2017 and was announced. We gave the provider 48 hours to make sure a member of the management team was available in the office to meet with us.

This was our first comprehensive inspection of this service since it registered with us on 19 May 2016. This service has been operating for 15 years and was previously registered with us at a different address. We inspected this service under their previous registration and we rated them good at our last inspection on 25 June 2015.

Rainbow Medical Services is a domiciliary care agency that provides personal care and support to people living in their own homes, many of whom were older people, some of whom were living with dementia. There were 63 people receiving services from Rainbow Medical Services at the time of our inspection.

Rainbow Medical Services provides nursing and care to support people who live across London. The services specialises in providing care to people who have complex health needs.

The service did not have a registered manager in post. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. However, two managers were in post who had both begun the process to register with CQC. One manager was a registered nurse who led on the clinical governance of the service, while the second manager led on operational oversight.

The provider managed people's medicines safely. The provider had good systems in place to assess, monitor and improve the service. These included revising the recruitment system to ensure only staff who were kind and had a passion for caring for people were selected.

Improved recruitment systems meant the provider also experienced more positive outcomes relating to staff management. Recruiting staff who had the right attributes and interest in caring for people meant incidents of staff misconduct significantly reduced. The provider also had excellent systems in place to listen to staff, gather feedback and act on it to improve the service, with good systems in place to gather feedback from people using the service. The provider had a range of audits in place to check the quality of service including accredited award schemes to audit the service. The provider also had excellent systems in place to recognise and reward staff, which meant staff felt motivated to provide high quality care to people.

The provider identified risks to individuals and put robust risk management plans in place to guide staff in mitigating risks to individuals, incorporating guidance from external professionals. This meant risks to people were reduced. However, the provider did not always follow best practice in carrying out and recording risk assessments according to a five step procedure, but told us they would standardise and

improve their processes. Care plans informed staff about people's individual needs, and the best ways for staff to care for them.

People were supported by staff who were recruited following robust procedures to check they were suitable to work with them. There were enough staff deployed to meet people's needs.

People felt safe when staff cared for them and staff understood how to respond if they suspected anyone was being abused, receiving training from the provider each year to refresh their knowledge.

Staff understood their responsibilities to provide care to people in line with the Mental Capacity Act 2005. The provider assessed people's capacity to consent to their care and took measures to provide care in people's best interests when they lacked capacity to consent.

The provider supported staff with a comprehensive programme of induction, training, supervision and annual appraisal. Staff were encouraged to complete diplomas in health and social care. The provider was trialling a staff reward system based around completion of diplomas in health and social care and length of service. In addition, the provider ensured staff completed specialist training to meet people's particular clinical needs.

People received the necessary support from staff in relation to eating and drinking and receiving sufficient nourishment when they required specialist equipment to eat and drink. The provider also catered to people's ethnic and cultural needs in relation to eating and drinking when necessary. People were supported by staff to access the healthcare services they needed where this was part of their care package.

Staff treated people with kindness, dignity and respect and respected their privacy. Staff understood the needs of the people they were caring for as well as their backgrounds, interests and preferences. Staff involved people in their care and supported people to maintain their independence.

People received care which met their needs and preferences. The provider involved people in reviewing their care and ensured information in care plans remained current and reliable for staff to follow.

The provider had systems in place to investigate and respond to complaints appropriately. However, they did not always record the action taken and reassured us they would review their systems to ensure all relevant details were recorded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. The provider managed people's medicines safely.

Staff knew how to recognise abuse and how to respond to it to protect people. There were enough staff to care for people and staff were recruited via robust processes to check they were safe to work with people. Risks to people were mitigated through robust risk management plans.

Is the service effective?

Good

The service was effective. Staff were well supported via induction, supervision, appraisal and training.

The provider assessed people's mental capacity to make decisions and staff understood the Mental Capacity Act 2005.

Staff supported people appropriately in relation to eating and drinking and supported people to access relevant healthcare services.

Is the service caring?

Good

The service was caring. Staff treated people with kindness and respected people's dignity.

Staff knew the people they were caring for, they understood people's needs and listened to them. People were involved in decisions relating to their care.

People were supported to retain their independent living skills as far as possible.

Is the service responsive?

Good

The service was responsive. People were provided with care that was responsive to their needs, according to their needs and preferences.

People were involved in assessing and planning their care. People's care was reviewed by the provider to ensure information for staff to follow was reliable.

Systems were in place for the provider to investigate any complaints people made.

Is the service well-led?

Good

The service was well-led. Staff felt very motivated as the provider had systems to recognise and reward their achievements.

The provider had systems to listen to people and staff.

The provider had a clear structure with visible leadership and an emphasis on constantly improving the service.

Rainbow Medical Services Ltd

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 checked 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 was a comprehensive inspection. The inspection took place on 16 August 2017 and was announced. We gave the provider 48 hours' notice of the inspection to make sure a member of the management team was available in the office to meet with us. The inspection was carried out by an inspector and an expert by experience who made phone calls to people and their relatives after the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection we reviewed information we held about the service. This included statutory notifications received from the provider since the last inspection and previous inspection reports. We also contacted the safeguarding team at a local authority in which the service provided care to people and received their feedback.

During the inspection we spoke with the operations manager, the clinical manager, the quality assurance and compliance manager, the chief executive officer, a care co-ordinator, the recruiter, the HR manager and seven care workers. We looked at a range of records including three staff files, six people's care plans, records relating to medicines management and other records relating to the management of the service.

After the inspection we spoke with eight people using the service and one relative via telephone.

Good

Is the service safe?

Our findings

The provider managed people's medicines safely. People told us they had no concerns about the way staff managed their medicines and people told us staff administered their medicines to them at the right time. One person told us, "If I am in pain, [staff] ask me what I want, via injection or tube." Medicines records were largely completed well by staff, although we identified a small number of omissions on some people's medicines records. During our inspection we queried whether the provider had also identified these omissions and investigated them and the provider did not provide us with evidence they had done so. However, after the inspection the provider sent us evidence they had identified and investigated these omissions, taking action to provide staff further support where necessary. The provider recently recruited a clinical manager who was improving medicines practices further. The clinical lead showed us records to evidence they had begun assessing staff competency in administering medicines safely. The clinical lead told us these competency assessments would be carried out each year.

The provider ensured risks to people were managed well to ensure their safety. The provider identified risks to people and put management plans in place to mitigate them. For example, the provider had clear management plans in place for how staff should mitigate risks relating to people's clinical needs. These plans included how staff should provide care to reduce the risk of infections and soreness relating to people's tracheostomies (equipment inserted into people's windpipes to help them breathe) and catheters (equipment to help people with their continence needs). In addition the provider had management plans in place to reduce the risk of pressure ulcers for some people. These plans included regular repositioning, checking people's pressure areas for redness and liaising with the district nurse regarding any concerns. The provider also trained staff in how to manage clinical risks to people, including tracheostomies, catheters and pressure ulcers. The provider reviewed risk assessments annually or sooner if risks to people changed. This meant information for staff to follow in mitigating risks remained current.

People were supported by staff who were recruited following robust procedures. The provider previously identified recruitment processes required improvements to ensure only staff who were passionate about caring for people were selected. The provider took robust action to improve by introducing a broader range of assessments and found this improved the quality of staff recruited. The provider obtained references from former employers and obtained criminal records checks. The provider also checked candidates' identification, proof of address, right to work in the UK as well as any health conditions which may affect their performance. The provider continued to check the suitability of staff for the role during their probationary period.

There were enough staff deployed to care for people; people, relatives and staff told us this. All the people we spoke with told us staff had enough time to sit and talk with them and were allocated enough time to support them well. One person said, "We have a chat, general conversation, no rush to get away." A care coordinator showed us how they prepared rotas four weeks in advance and told us they did not experience any difficulties in ensuring all visits were assigned as there were sufficient staff. The operations manager told us the managers, care co-ordinators and field care co-ordinators were available to carry out care to people if necessary, but it was rare that their support was required.

People received care from staff who knew how to safeguard them from abuse and neglect. All the people we spoke with told us they felt safe when receiving care from the provider. A relative told us, "My [family member] is perfectly safe when [the care workers] are in the house." Our discussions with staff showed they understood the signs people were being abused and how to respond if they suspected people were being abused. Staff were aware of the whistleblowing policy and told us they were confident the provider would respond appropriately to protect people if they reported any concerns. Staff received training in how to safeguard people from abuse each year to keep their knowledge up to date. There were two safeguarding allegations against the provider in the past 12 months which had been investigated by local authority safeguarding teams and were not upheld, and the provider complied well with these investigations.

The provider took the right action in response to accidents and incidents to keep people safe. Staff recorded details of accidents and incidents and the quality assurance and compliance manager analysed reports to ensure people, and staff, received the necessary support when accidents and incidents occurred. The provider maintained a spreadsheet of accidents and incidents which was regularly reviewed to identify any patterns and to determined action to take to reduce the risk of reoccurrences.

Good

Is the service effective?

Our findings

People were supported by staff who received good support from the provider, with a programme of induction, training, supervision and annual appraisal. Newly recruited staff completed a thorough induction during which they learnt how to care for people well. New staff attended a two day in-house training course during which they covered a range of training topics including moving and handling, mental capacity act, safeguarding and infection control. Staff who had no experience of care attended an additional three day training course during which they covered an introduction to care course. All staff shadowed more experienced staff then worked with another member of staff with people who required two care workers to gain confidence in their role. Staff who had no experience of care shadowed staff for a longer period of time. Field care supervisors worked closely with all new staff, observing their practice and providing additional support before assessing them as competent to care for people alone. New staff also completed the skills for care 'care certificate'. The Care Certificate is a national qualification developed to provide structured and consistent learning to ensure that care workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe, quality care and support. This meant staff were reaching the standards expected of care workers nationally during their induction period.

Staff told us the training provided was high quality and relevant to their role. People all told us they found staff to be well trained to meet their needs. One person told us, "They are very highly skilled nurses". Staff completed a programme of mandatory training in topics relevant to their role. In addition staff were provided with training specific to the complex needs of the people they supported. For example, staff received training in tracheostomy care, catheter care, end of life care and dementia awareness. The provider also supported staff to complete diplomas in health and social care. Staff were able to request any additional training relevant to their role which the provider would then arrange. The provider employed a trainer and had a dedicated building at a separate location where they carried out training, which housed equipment such as hoists to facilitate certain courses. The provider often arranged for their staff to work alongside hospital staff for a few days to learn how to best meet people's complex care needs

Staff received four supervision sessions each year during which they reviewed the best ways to care for people and their personal development and training needs were discussed. During supervision sessions staff were asked what training they would like in terms of their personal development. The quality assurance manager recorded all training requests on a spreadsheet each month. They then liaised with the trainer to provide the courses requested based on demand. Staff also had their performance observed four times each year by field care supervisors, from which they received feedback and were supported to make any improvements necessary. Staff told us they felt well supported by the provider.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). There is a separate process for services which support people in their own homes.

People were cared for by the staff in line with the MCA. This was because staff understood their responsibilities in line with the MCA and received training each year from the provider to keep their knowledge current. The provider carried out mental capacity assessments to determine people's capacity to consent to decisions relating to their care and recorded a summary of their findings in people's care plans for staff to refer to. Where people were found to lack capacity the provider consulted with others involved in their care, such as relatives and social workers, to make decisions in people's best interests. The provider recorded evidence of the views of others involved in people's care during pre-admission assessment and care plan review meetings, although these views were not formally recorded as part of best interests planning. The provider told us they would review their processes relating to planning care in people's best interests when they lacked capacity and systems for recording people's views.

People were supported appropriately by staff in relation to eating and drinking. People all told us they received their choice of food where staff were responsible for providing this. A relative told us, "There are loads of [food] options for [my family member]." Some people had specific requirements in relation to eating and drinking, such as equipment to provide nutrition directly into their stomachs or other regions of their digestive system. The provider ensured only staff who received training in relation to these specific needs provided nutritional support to people. The provider recorded clear guidelines in people's care plans for staff to follow in providing this nutritional support. The operations manager told us where people preferred to eat particular ethnic or cultural foods they assigned staff with the required skills and backgrounds to work with them as far as possible. They gave an example of when they assigned a suitable care worker to a person who requested support from staff who could cook food of their ethnic and cultural background.

People were supported by staff in relation to their health needs. Many people had complex healthcare needs and the provider ensured their care plans contained detailed information and guidance for staff in relation to these. For example, for a person with complex physical needs and a history of depression their care plan contained detailed guidance from the team of professionals that worked with them for staff to follow. Their care plan contained signs the person could be becoming depressed and how staff should respond, such as encouraging them to discuss their feelings, ensuring they were given as much choice as possible in their care and encouraging them to take part in activities. Contact details for professional involved in people's care were also available for staff to follow, as well as guidance on when staff should contact them.

Good

Is the service caring?

Our findings

People were supported by staff who were caring and treated them with dignity and respect. When we asked people if staff were kind to them, all responded positively and one person said, "Yes, they most certainly are." Again, all people were positive when we asked if staff treated them with dignity and respect. One person said, "I think so. Just because I am disabled, I've got all my marbles." Another person said, "Yeah, they treat me like an ordinary person." Staff also respected people's privacy and dignity. One person told us, "[Staff] make sure no one can see me when I am undressing." Another person said, "They don't intrude. When the nurse dresses my wound they wait." Another person told us, "When they look after me, they leave me but [they are] close-by so that I can get help from them." Staff we talked with spoke about caring for people in a passionate way and it was clear they enjoyed their roles.

People received care from staff who knew them, understood their needs and listened to them. One person told us, "[Care workers] always pick up when I am in pain. I don't have to tell them." People all told us they benefited from consistency of care workers which meant staff came to know people well over time. One person said, "I have regular carers. My carers usually stay with me for years."

People all told us care workers spent time conversing with them, that they usually arrived on time and did not rush their work. One person said, "[My care worker] made herself a cup of coffee… and talks to me whilst she is writing the logbook". In addition all people we spoke with told us the service provided them with staff of their preferred gender. One person said, "[Nurses] have to be female because of the personal aspect. They just gave me all female nurses." The care-coordinator we spoke with had a good knowledge of people's individual needs and preferences. The care-coordinator showed us how they selected care workers according to people's preferences, such as gender preferences, to work with them. The recruiter told us how they got to know staff during their induction period and matched staff to people based on shared interests and similar personalities.

People were involved in their care by the provider. When we asked people whether care workers listened to them one person said, "Oh yes, [the care worker who supports me] does listen to me." People all told us care workers offered them choices. One person told us, "I go through the shopping list with [my care worker]" when we asked how care workers involved them in their care.

People were supported by care workers to maintain their independent living skills. When we asked people if care workers encouraged them to be independent, one person told us, "As much as I can be." A relative told us care workers, "challenge [my family member] … to be as independent as possible." The operations manager gave us an example of how they supported a person who experienced a permanent and severe change to their mobility to regain their independence and live alone, according to their wishes.

Good

Is the service responsive?

Our findings

People were involved in assessing and planning their own care by the provider. One person said, "I feel extremely fortunate to be looked after very, very well." When people were referred to the service the provider reviewed professional reports to check they were able to meet their needs in the first instance. Then a member of the office team met with people and their relatives to find out more about how people wanted to receive their care. The provider recorded details of people's backgrounds, health and social care needs and their preferences in their care plans for staff to be aware of when providing care to them.

People received care according to their clinical needs and preferences. One person told us, "The manager of Rainbow thought carefully what I needed, either A & E or intensive care trained nurses." Another person said, "[Care workers] are thorough when doing the personal wash. They make sure I don't have bed sores." The providers' electronic rota planning system ensured only staff with required specialist skills and knowledge worked with people, such as ensuring only staff who received tracheostomy worked with people who had this specific requirement. People's care plans also contained details of how staff should involve people in their care, including offering choices and what aspects of their care people should be prompted to do for themselves. Care plans were sufficiently detailed to inform and guide staff in relation to all people's identified needs, including their communication needs. For example, one person's care plan guided staff on how the person communicated via gestures and a spelling board as they were non-verbal.

People's needs were reviewed regularly by the provider. The provider reviewed care plans every six months or more often if people's needs changed, which meant information in people's care plans was up to date and reliable for staff to follow. The provider involved people in the review process by meeting with them and their families to discuss how well their care package was meeting their needs.

People were encouraged to complain and the provider had systems in place to investigate and respond to people's complaints. People told us they would complain to the provider if necessary. Some people had made complaints and told us they had been dealt with to their satisfaction. For example, one person told us they were not happy with a care worker and they were removed when they complained. However, records showed the provider did not always record the action they took in response to complaints and the outcome, including whether people were satisfied, to ensure a complete audit trail. The quality assurance and compliance manager told us they would review their recording systems to include this information in future when we fed back this issue. The provider told us the action they had taken to resolve each complaint and we found this was appropriate in each case. The agency made the complaints policy available to people as it was summarised in information about the service the provider gave people when they began receiving care.

Good

Is the service well-led?

Our findings

People received care and support from a service that was well led. People, relatives, commissioners and other local authority representatives we received feedback from spoke positively of the service. One person told us, "I am very satisfied with Rainbow services. No criticisms, doing a very helpful job." Another person told us, "I am just very happy with Rainbow and the nurses, so far so good." Another person told us care workers were "incredibly helpful." A commissioner told us the provider took remedial actions when they brought some concerns to their attention a few months ago, and the person and their family were satisfied with these improvements.

Although there was no registered manager in post the provider had appointed two managers who were registering with CQC. The previous registered manager deregistered with us in March 2017. This meant the provider had taken sufficient action to ensure the period of time they were without a registered manager was a short as possible. The provider recently reviewed the structure of the organisation with a view to improving the governance of the service. The provider decided to appoint two registered managers to have clear and distinct leadership of the operational and clinical aspects of the service. A registered nurse had been appointed to take the clinical lead. The operational lead was taken by an experienced member of staff who had been supported, developed and promoted by the provider. The structure of the organisation meant there were distinct departments, including HR, finance and IT, with visible leadership and each staff member had a clear understanding of their role and responsibilities.

People were supported by staff who felt motivated and appreciated by the provider. Staff told us they were often complimented on their performance by the management team, and received written thanks and praise when they 'went the extra mile'. One staff told us it was "better than money" to receive such recognition of their work. The provider also held an annual award ceremony during which staff received various awards for their achievements over the previous year. The CEO told us they reviewed the pay and benefits awarded to staff to reflect their appreciation of staff and encourage staff development with a view to achieving high levels of staff retention. For example, the CEO told us they paid staff at the upper levels allowed by their contracts with local authorities across London. In addition the provider was introducing a scheme to increase pay based on length of as well as qualifications achieved such as diplomas in health and social care. The provider was also introducing a package of benefits to staff which included discounts on healthcare and high street retailers and an employee assistance line to provide counselling and advice.
People's views on the service were actively sought by the provider and acted upon. The quality assurance and compliance manager told us the provider used to send annual questionnaires out to people to gather their views. However, they experienced poor response rates and found people were not always forthcoming with sharing their views. One person told us, "[The provider] knows my feelings about the service and my appreciation, therefore a questionnaire wouldn't add very much, like a tick box exercise." Because of this the quality assurance and compliance manager reviewed systems and implemented a system where they personally visited people at least once each year to gather their views in person. The quality and compliance manager told us they found this was a much better way to engage people and encourage them to share their experiences and ideas regarding the service in more depth.
The provider also had systems to gather the views of staff to help improve the service. Each staff member

received four supervisions per year during which they were always asked for their views on the service and areas where improvements could be made. The quality assurance and compliance manager recorded these views on a spreadsheet each month and implemented improvements where necessary. In addition, the provider recently sent out the annual questionnaire to staff. We viewed the analysis the quality assurance and compliance manager had carried out using the feedback received. We observed the provider had captured every comment received in their analysis. While most feedback was positive, the provider identified a common theme regarding poor communication from some office staff. In response to this the provider took measures to improve communication, including providing customer service training for some office staff.

People were supported by staff who felt the provider communicated well with them. Staff told us they could speak with staff at the office during office hours to receive guidance if required. In addition staff told us there was an on call system and they could get hold of one of the management team at any time. The provider issued a newsletter in July 2017 to update staff on developments within the organisation, and this was intended to be a monthly newsletter. The provider also held forums twice a year which people using the service and staff were invited to share their views on the service as well as where improvements could be made. People told us office staff communicated any changes to them clearly and were "friendly" and "nice people."

The provider had quality assurance processes in place to check the quality of the service people received. A quality assurance and compliance manager was in post who had systems in place to assess, monitor and improve the service. Each care worker was observed by a field care supervisor on four occasions each year. During these observations, which were often unannounced, the quality of care provided was assessed on a range of measures. Field care supervisors provided care workers with feedback from each observation and supported them to make improvements where necessary. Each month the quality assurance and compliance manager actively monitored staff supervision, appraisal, training, accidents and incidents, complaints and any allegations of abuse by reading all relevant reports and summarising them in spreadsheets. The provider also audited staff files and care plans to ensure they contained the necessary information. The findings of the quality assurance processes were discussed during regular management meetings and improvements made where necessary.
The provider was accredited by an independent body, the International Organization for Standardization (ISO), for the management of specialised health care and social services relating to quality, the office environment and health and safety. Reports from audits carried out in June and July 2017 evidenced the provider had successfully achieved reaccreditation.

The provider maintained records well and ensured they contained an accurate record of the care provided to people. However, we identified an area for improvement relating to risk assessment records. The provider used a template which followed the Health and Safety Executive's (HSE) five steps to risk assessment in assessing risks relating to the environment people lived in. For all other risks it was not always clear how the provider had carried out the assessments. This was because the provider summarised the risks and the management plan within the care plan without showing their full assessment. This meant it was not always clear how the provider had assessed the level of each risk, although discussions with the operations manager assured us the levels were accurate. The provider told us they would standardise their risk assessment procedures and ensure all assessments were clearly recorded.