

G P Homecare Limited

Radis Community Care (Leeds)

Inspection report

SF01/SF02 City Mills
Peel Street
Morley
LS27 8QL

Tel: 01132523461

Date of inspection visit:
02 August 2016

Date of publication:
03 November 2016

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This was an announced inspection carried out on 02 August 2016. Our last inspection took place on 29 August 2013 when all of the regulations we looked at were met.

Radis Community Care (Leeds) is a domiciliary care agency which provides personal care to people living in their own homes and provides assistance and support to people to help them maintain and improve their independence.

At the time of our inspection the service did not have a registered manager, although in March 2016 a branch manager had been recruited to the post and was in the process of becoming registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The inspection concluded the administration of medicines was not always safe as staff competency checks had not been carried out. Protocols for 'as and when required' (PRN) medicines were not in place and there were some gaps in the recording on medication administration records (MAR's). However, a sample of daily notes showed people were receiving their medicines and staff had received medication training.

Staff were able to confidently describe how they would identify a person was being harmed and felt confident the management team would take appropriate action. They were aware of the registered provider's whistleblowing policy and knew how to report abuse externally. Safeguarding notifications had been submitted by the branch manager to CQC and the local safeguarding authority.

Recruitment processes were effective which meant people were protected from individuals identified as not suitable to working with vulnerable adults. Risks to people had been identified, assessed and reviewed.

People received visits at expected times and when this was not possible they were kept informed of any delays. People were supported by regular staff members who were familiar with them and their needs. Positive feedback was given from people and relatives regarding the staff who provided their care and support. Staff knew how to protect people's privacy and dignity and people confirmed this happened.

Staff received effective support through their induction, supervision sessions and ongoing training. A programme of appraisals had also commenced. Quarterly staff meetings were held and staff confirmed they were able to express their views. Staff liked the branch manager and there was a positive culture amongst the staff team.

Staff had received training in the Mental Capacity Act (2005) (MCA) and knew how this applied to their work. Staff told us about the importance of offering people choice and people confirmed this happened.

Appropriate guidance was in place to ensure people received enough to eat and drink. Staff were able to recognise and report when people's healthcare needs changed. When this happened, referrals were made to healthcare services to ensure people received the necessary assistance. Examples of staff ensuring vulnerable people were protected from harm were evident.

Complaints were effectively managed and most people knew how to complain if they were dissatisfied. Quality management systems used by the registered provider did not always ensure appropriate checks were being made to improve service delivery. We found there was no record of the area manager's visits to evidence their oversight of the service.

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

Medicines were not always safely managed due to gaps in recording, not having staff medication competency checks and PRN guidance for staff to follow.

Recruitment procedures were found to be effective. Staff knew how to identify and report concerns about abuse. Risks to people were assessed, managed and reviewed.

People received a service from regular staff who arrived on time and were familiar with their care and support needs.

Is the service effective?

Good 

The service was effective

Referrals were made to services which ensured people had access to healthcare. People received support to ensure they received enough to eat and drink.

Staff received appropriate support during their induction and through supervision sessions. Appraisals had recently commenced. Staff were up-to-date with their training.

Staff understood the MCA and how this affected their work. People confirmed they were given choices by staff.

Is the service caring?

Good 

The service was caring

People and relatives spoke positively about the service they received from staff. Staff went above and beyond their duties to provide support which ensured people were not left in vulnerable situations.

Staff were able to describe how they protected people's privacy and dignity and people and relatives confirmed this happened.

Is the service responsive?

Good 

The service was responsive

People were involved in agreeing their care plans. Care plans were sufficiently detailed and found to be personalised. Regular reviews were taking place and people confirmed this happened.

Complaints were effectively managed as we saw evidence of investigations and responses. People who had complained were satisfied with the outcome.

Is the service well-led?

The service was not always well-led

Staff spoke positively about the branch manager and there was a positive culture within the service. Staff confirmed they were listened to.

Quality management systems were in place, although these processes had not identified gaps in the safe management of medicines. There were no records of the area manager's visits to evidence their oversight.

Team meetings, satisfaction surveys, telephone contacts and branch spot checks helped to ensure the service was well-led.

Requires Improvement ●

Radis Community Care (Leeds)

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 was an announced inspection carried out on 02 August 2016. 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 inspection team consisted of one adult social inspector who visited the premises and made telephone calls to people who received this service, their relatives and also spoke with staff members.

At the time of our inspection there were 76 people using the service who received personal care. We spoke on the telephone with five people who used the service and three people's relatives. We spoke with five members of staff, the branch manager and the regional director. We spent time looking at documents and records that related to people's care and the management of the service. We looked at seven people's care and support plans.

Before our inspection, we reviewed all the information we held about the home, including previous inspection reports. We contacted the local authority and Healthwatch. Healthwatch stated they had no comments or concerns about this service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also contacted the local authority who told us they had no reported concerns.

Before the inspection the provider completed a 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 improvements

they plan to make.

Is the service safe?

Our findings

We looked at the management of medicines and found this was not always safe. We looked at medication administration records (MAR's) for seven people and found gaps in recording. For example, one person's MAR showed their morning medicines of Levothyroxine and Aspirin as not given on 26, 27 and 29 May 2016. We sampled daily notes and found evidence which showed these medicines had been administered, but not recorded on the MAR. We saw evidence of medication audits which had been introduced in April 2016, although gaps in medication errors had not been identified.

There were no formally recorded staff competency checks for administering medicines. We found this had been highlighted in the 'Leeds spot check' dated February 2016. We also saw there was no guidance for staff to refer to for administering 'as and when required' (PRN) medicines. This meant staff may not have been able to identify occasions when people should have been offered these medicines. This was discussed with the branch manager and regional director who told us they would have medication competency checks and PRN protocols in place for staff by October 2016.

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

People we spoke with were satisfied they received appropriate assistance from staff with their medicines. Staff members we spoke with were able to describe how they safely administered medicines to people. One staff member said, "We can only give what's prescribed. I record what I've given." We saw body maps were used to show staff where they should apply topical creams and lotions.

Staff told us they received medication training as part of their induction and on an ongoing basis through refresher training. Training records we looked at showed all staff had received up-to-date medication training. We also saw medication was a standing item discussed with staff during supervision sessions.

We looked at the records relating to a medication error which took place in April 2016 and found this had been well managed. Following this event, one staff member had been booked on to re-take their medication training and we saw discussions about administering medicines at their supervision the following week.

All staff we spoke with were able to confidently describe different types of abuse and how they would identify a person was being harmed. One staff member told us, "You can tell in a person when something's wrong. I would go straight to my manager." Staff also identified they could use the registered provider's whistleblowing policy to report their concerns. Whistleblowing' is when a worker reports suspected wrongdoing at work. Staff also knew how to report abuse to external agencies responsible for investigating such concerns.

We saw seven members of staff who needed refresher training in safeguarding awareness had already been booked on to this course for the week following our inspection. We looked at the systems for recording allegations of abuse and found appropriate referrals had been made to the CQC. Investigations had been

carried out in conjunction with external agencies and we saw these were documented.

We looked at the systems used to coordinate services which were provided to people who lived in Leeds, Kirklees and Wakefield and found these were well managed. The registered provider operated a call monitoring system which meant they were able to track calls 'live' and identify lateness. The branch manager told us they sampled and monitored call times on a daily basis.

People and relatives told us staff were usually on time for their visits and if there were delays these were communicated to them in advance. We asked one person if staff arrived on time and they told us, "Nine times out of 10." One relative told us, "They do keep us informed." However, one person expressed that when regular staff were unavailable, their replacements were not as punctual. People and relatives told us they had not experienced any missed visits. Staff told us communication from the office was usually good when changes were made to their rotas.

People and relatives confirmed they were usually cared for and supported by a regular group of staff who were familiar with their care needs. The branch manager told us, "Continuity is a big thing for us." We asked people whether they received a copy of their rota. One person said, "Yes, they say who's coming out. I get a weekly rota and they're usually bang on."

Staff gave us mixed feedback regarding the amount of travel time they were allowed between visits. Whilst some thought they had enough time, others were more critical about unrealistic travel time they were allocated. We found the arrangements for the out of hours duty system were effective.

Risks to people were appropriately assessed, managed and reviewed. We looked at seven care plans and saw relevant risk assessments were in place. For example, environmental risk assessments considered smoking, food preparation, the use of chemicals, medicines and fire evacuation. A risk assessment for one person's skin contained clear guidance for staff to follow. Moving and handling risk assessments were completed where people needed staff to assist them.

Staff were able to describe the action they would take in response to an emergency. One staff member told us they had recently arrived at a call where a person had fallen. We found they had taken appropriate action in response to this incident.

We looked at the recruitment processes followed by the registered provider for three members of staff and found these were safe. Staff were required to have references in place, although in one staff file, the last employer reference was not available. Instead, a second character reference had been taken. We saw evidence of checks having been made with the disclosure and barring service (DBS). The DBS is a national agency that holds information about criminal records. This helped to ensure people who used services were protected from individuals who had been identified as unsuitable to work with vulnerable people.

Is the service effective?

Our findings

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.

Staff had completed MCA training and were able to demonstrate a sound knowledge of how this applied to their work. They told us they offered people choices and people we spoke with confirmed this happened. For example, one person said, "They ask me what I want for breakfast." We saw evidence of consent to care forms which were appropriately completed in people's care and support plans.

We looked at a care and support plan for one person who was living with Dementia and lived on their own. A section which asked, 'What is in place to support this service user to make decisions and choices' had been left blank. We discussed this with the branch manager who told us they would carry out a mental capacity assessment for this person.

We asked people and relatives whether they thought staff were competent in their role. One person told us, "I think they're competent enough. They do vary a bit. The regular ones seem to be very good." One relative commented, "I can't fault any of them."

On the day of our inspection we saw a group of new staff members starting their induction. This involved four days of classroom learning during which staff completed a competency and assessment book, 32 hours of e-learning as well as a minimum of one week shadowing. Staff we spoke with felt very positive about the induction they received which they said helped prepare them for their role.

The branch manager told us staff were scheduled to receive quarterly supervisions. New starters received more intensive support with weekly supervision during the first month of their employment. The records we looked at showed staff received this support. We asked one staff member about their supervision and they told us, "I feel like I can discuss things. They're quick to act on things." Since their appointment in March 2016 the branch manager had started a programme of appraisals and had completed eight of these. They had a schedule for the remaining staff appraisals.

We looked at the training matrix and found staff were up-to-date with their training programme and refresher training had been booked. We were made aware of specialist training staff had received to be able to provide care and support specifically for two people who received a service.

We saw evidence in one person's care plan which showed their mobility had deteriorated. In response, the branch manager made a referral to the moving and handling team at the local authority. This meant appropriate action was taken when people's healthcare needs changed. Another person's telephone line was faulty which meant they would be unable to use their emergency response pendant in an emergency.

We saw the registered provider was in contact with the telephone service provider, local authority and family member.

One relative told us staff were good at spotting when their family member had developed an infection. This meant they were able to arrange for support and treatment from their GP. Staff confirmed they were encouraged to report changes in people's health to families and staff in their office. One staff member told us, "I do keep them informed about any changes in people"

We looked at how staff ensured people received enough to eat and drink. One relative told us, "They encourage him to have a drink." A staff member told us, "One person has water. I always leave him with a full glass." We looked at one person's care plan and found it provided staff with clear instructions about how much thickener they needed to apply to ensure the person was able to drink without being at risk of choking. Another person's care plan stated their food preference, 'I like cheese omelettes and sometimes Cornish pasty with soup or gravy poured on it'. This meant appropriate support and guidance was in place to ensure people had enough to eat and drink.

Is the service caring?

Our findings

People and relatives we spoke with told us how staff demonstrated the right values used to deliver safe, kind and compassionate care. They expressed they were very satisfied with the care they received. One person said, "They're friendly and professional and do the job to a high standard." Another person commented, "The ones who have been are excellent. They have been absolutely brilliant." A third person said, "They're nice and seem genuine". A fourth person told us, "I find that all the lasses are good."

People told us they were supported at a pace which they wanted to receive their care and support. One person said, "I never get rushed" and a relative we spoke with told us, "If they to do anything it's at [name of person's] pace. It's like safety first." Staff we spoke with were confident people received good care. One staff member said, "I treat them how I'd treat my own."

People and relatives confirmed staff were familiar with their care and support needs. Comments included; "He's got a good rapport with them" "They give him his time. They talk to him" and "They're very cheerful and they'll have a laugh with [name of person]. They're very caring. They want what's best for [name of person]. He feels special. They sit and talk to him for ages. He looks forward to them coming."

The registered provider's PIR stated, 'If a service user has company when the care workers attend for the call the care worker should be asking the service user if they wish their call to continue. This is to ensure that their privacy and dignity is respected'.

People and relatives who we spoke with confirmed staff knew how to respect their privacy and dignity and applied this to their work. One relative told us, "They're very good. She always knocks on the bathroom door. They're very respectful." Another relative commented, "They knock on doors and ask if they can use the phone to sign in. They always greet [name of person] with respect." We found staff were able to describe the different ways in which they helped to protect people's privacy and dignity. One staff member told us, "I cover people with a towel until I'm washing them. I give them their independence so they can do what they can."

During our inspection we were made aware that one person was receiving bogus telephone calls. As this person lived alone, staff were concerned about them being vulnerable and contacted the office. This information was then communicated by the office staff to the person's social worker which meant appropriate action could be taken to minimise the risk of harm to this person.

We saw evidence of compliments received by the registered provider, one of which stated, 'Special thanks to all my angels who gave us all the support and friendship through [name of person's] illness. I will always be grateful for your help'.

Is the service responsive?

Our findings

The registered provider's PIR stated, 'Service user care plans are written with the person being in the middle of care decisions, ensuring that the choices of each individual are respected; and their right to choose how things are done ensuring they have full dignity in all areas of their care plan'.

There was evidence the people who received this service had been involved in planning their care and support needs. People told us they had spent time with staff in agreeing their care and support plan. One person said, "They sat with me and asked me what I needed." One relative we spoke with confirmed staff read their family members care plan and then researched the person's medical condition as preparation. They told us "You could see how keen they were."

We looked at a range of care plans and found these contained detailed information about people's care and support needs and how staff should provide this assistance. Care plans were written from a first person perspective and were personalised to individual needs. For example, one person's care plan stated, 'I will let the care workers know if I would like a wash or shower each day they visit'. Care plans contained records about what was important to the person which covered, for example, hobbies and interests, religion, healthcare needs, medication, personal care and cooking and meal preparation. We also saw step-by-step guidance in every care plan which described in detail the tasks staff were expected to carry out at each call.

We found a needs assessment overview which was a one page sheet that provided staff with a quick summary of people's overall care and support needs. This meant staff who were carrying out visits to people for the first time had a summary to refer to.

We asked staff about care plans and found they were satisfied they contained sufficient detail and were kept up-to-date. "Most of the time they've got more detail than they need." "Another staff member said, "Some are quite in depth. The risk assessments and medication are always there."

The regional director told us that the policy for reviews of people's care plans was to do this annually, although they encouraged six monthly checks. We saw evidence of people's care plans being reviewed regularly and people we spoke with confirmed this happened. One relative we spoke with told us, "We've just had a review with [name of branch manager]." The branch manager told us they were developing a service user review matrix which would help them more readily identify when reviews were due to take place.

We looked at the system used by the registered provider to recognise and respond to complaints and found this was effective. An up-to-date complaints policy was in place and where complaints had been received, we saw these had been recorded, investigated and responded to appropriately.

We asked people if they knew how to complain and found some people were not sure. One person told us, "I'd pick the phone up and speak to who's in charge." Two people we spoke with made us aware they had previously raised a complaint, although both added this was resolved to their satisfaction.

The registered provider's PIR stated, 'Staff will be encouraged to learn about the local area and services available to service users in order to promote them (clubs, shops, other agencies) ensuring that all options are being made to the service user in order for them to make an informed decision on their care, home and leisure / social activities'. This meant people would receive support to keep in touch with their local community.

Is the service well-led?

Our findings

At the time of our inspection the branch manager told us they had commenced their application to become registered with the Care Quality Commission.

We were made aware the area manager visited the service on a regular basis, although there were no records of their oversight of the service. However, the branch manager told us they felt supported in their role.

We looked at the 'Leeds spot check' carried out in November 2015 and February 2016. The regional director acknowledged there had been a gap since February 2016 and told us they would be moving to a new system which would give the service a quality rating of red, amber or green. We saw concerns gaps in medication recording had been identified, although based on our findings during this inspection, this had not been remedied.

The spot checks we looked at were effective as they looked at a sample of care plans, staff files, staff training and policies and procedures and contained an improvement action plan which fed into the overall service action plan. The findings from these checks were open, transparent and designed to improve service delivery.

From our observations in the office during our inspection and conversations with staff, it was evident there was a positive culture within the staff team. One staff member told us, "Everyone's easy to get on with." Another staff member said, "They're friendly and welcoming."

Some people we spoke with told us they were not familiar with the new branch manager. We discussed this with the branch manager who told us they would ensure people were made aware of their appointment. We asked staff about the branch manager and their comments included; "She's actually brilliant. She's the best manager out of the lot I've had" "She knows the service users. She seems to be doing a good job. She's easily approachable" and "I like [name of branch manager]. She's doing her best"

The registered provider's PIR stated, 'There is an Action Plan within the branch for the support team to monitor the process of the actions. The action plan is a working document and is updated to ensure that the service is reaching company expectations. This also assists demonstrating the positive changes to the care team'. We looked at the ongoing action plan and found this was an effective tool which included evidence of action taken, action needed and response times.

We saw evidence of a staff survey which had been carried out in January 2014 although the number of responses was very limited. We looked at the results of the service user satisfaction survey carried out in May 2016 and found the feedback was very positive. The results of the survey were used to form a report and actions fed into the registered provider's overall service action plan. We saw 28 people responded to the survey and found any concerns raised were responded to appropriately.

People told us they received regular telephone contact from staff in the office to ensure they were satisfied with the service they received. One person said, "I do get a phone call once a month to ask if everything is okay." We also found people received satisfaction questionnaires. This meant the registered provider listened to people by giving them regular opportunities to comment on the service they received.

We found evidence of team meetings which had taken place in March and June 2016. These covered areas including training needs, rotas, administering medicines and care plans. Staff told us these were two way discussions where their thoughts and opinions were listened to. The branch manager told us they would continue to hold quarterly staff meetings.

Staff we spoke with confirmed they had been spot checked to ensure they provided safe and effective care for people. We saw evidence of these checks having taken place in staff files. We also saw spot checks were timetabled to ensure each staff member's practice was observed and assessed. This meant the branch manager was able to recognise positive practice and take appropriate action where improvements were necessary.

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 12 HSCA RA Regulations 2014 Safe care and treatment The systems used to ensure the safe administration of medicines were not sufficiently robust.