Redyfne Recruitment And Staffing Limited

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Inspection report

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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 the first inspection of this service. The inspection took place on 7, 9 and 13 November 2017. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats and provides a service to older adults. At the time of the inspection the service was supporting 26 people.

The Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

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

This is the first time the service has been rated Requires Improvement.

Risk assessments were in place and people's individual risks were noted. However, there was no written guidance for care staff on how to mitigate the known risks. People had regular carers and staff that we spoke with were aware of risks to people and how to manage them.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. However, the policies and systems in the service did not support this practice. People received regular carers that knew them well and ensured that people had choice but people's ability to make decisions was not documented in care plans.

Care plans documented care tasks that staff needed to carry out. Care plans did not state people's likes and dislikes and how they wanted their care to be delivered. However, staff usually worked with the same people and were aware of people's likes, dislikes and how they preferred their care to be given.

The service did not administer medicines to any people that were supported. However, care workers did prompt people to take their medicines where necessary. Care workers were aware of the difference between prompting and administering medicines.

People received a continuity of care. The provider always tried to ensure that the same care workers looked after people. This promoted good working relationships with people who used the service.

The service was aware of how to ensure infection control when working with people. Staff were supplied with gloves and aprons to ensure that people were safe.

People and relatives were positive about the care that they received.

Staff received regular supervision and appraisal that helped them identify areas for learning and development. Supervisions and appraisals were used as an opportunity for staff to improve care practices.

People and relatives were involved in planning care and reviews of care.

At this inspection we found a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Where there were breaches of regulations, you can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Risk assessments noted what people's individual risks were but failed to provide staff with guidance on how to minimise the known risks.

The service provided prompting to ensure that people were taking their medicines. The service did not administer medicines.

Staff were able to tell us how they could recognise abuse and knew how to report it appropriately. Where safeguarding had been reported, the service had dealt with these appropriately to ensure people's safety.

There were sufficient staff to ensure people's needs were met. People experienced a continuity of care and often had the same care workers visiting them.

The service had protocols in place to ensure appropriate infection control, such as gloves and aprons.

Is the service effective?

Good

The service was not always effective. People's capacity had not been documented on their care plans. Capacity had not been taken into account when planning care. However, staff were aware of people's capacity and needs.

Staff received regular training, supervision and appraisal that supported them in carrying out their role.

People told us that staff knew their food and dietary preferences.

Peoples healthcare needs were monitored and referrals made when necessary to ensure wellbeing.

Is the service caring?

Good

The service was caring. People were supported by staff that understood their needs. People and relatives were very positive about the care provided.

People were treated with respect and staff maintained privacy

and dignity.

Staff understood and were positive about equality and diversity.

People were supported to be as independent as possible.

Is the service responsive?

Good

The service was not always responsive. People's documented care was not always person centred and care plans were not detailed. People's likes and dislikes were not noted. However, staff knew and understood people's individual likes and dislikes.

Staff were knowledgeable about individual support needs.

There had been no complaints. There was a complaints system in place and people and relatives were aware of how to complain.

Is the service well-led?

Requires Improvement

The service was not always well-led. Risk assessments failed to provide guidance for staff on how to minimise people's personal risks. The Mental Capacity Act had not been adequately applied and people's capacity taken into account when planning care. People's care plans were not always person centred and failed to note people's likes and dislikes. These issues had not been identified and addressed by the service.

There was an open and transparent culture where good practice was identified and encouraged.

There were systems in place to monitor care visits and ensure that people received visits on time.

Telephone monitoring and surveys were carried out to assess the standard of care. Where issues were identified, these were addressed.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 7 and 9 November 2017. We visited the office location on these dates to see the manager and office staff; and to review care records and policies and procedures.
Following the inspection phone calls were made to people, relatives and staff to gain feedback on 13 November 2017. The inspection was carried out by one adult social care inspector.

We gave the service 48 hours' notice of the inspection visit because it is a small domiciliary care agency and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Before the inspection we looked at information that we had received about the service and formal notifications that the service had sent to the CQC. We also looked at safeguarding notifications that the provider had sent to us. Providers are required by law to inform CQC of any safeguarding issues within their service.

During the office based part of the inspection we spoke with three staff including the registered manager, the deputy manager and the field care supervisor. We looked at eight care records and risk assessments, six staff files, and other paperwork related to the management of the service including staff training, quality assurance and rota systems. Following the inspection we spoke with six relatives, three people and two care staff.

Requires Improvement

Is the service safe?

Our findings

There were separate risk assessments for people in place. Each risk assessment asked standard questions regarding people's risks around nutrition, personal hygiene, if people were able to feed themselves, mobility and budgeting. This section provided general information on whether this was a risk or not.

The risk assessments then had a section called 'identified risk' where risks to the individual were identified. For example, risk of falls or short term memory loss. There was then a section for the outcome of the risk assessment that noted how the identified risk should be managed. However, for all risk assessments that we looked at there was not adequate guidance for staff on how to mitigate the identified risks. For example, for one person at risk of falls the risk assessment noted their past medical history and stated that it 'impacted on [persons] mobility and cause her falls'. There was no guidance for staff to ensure that they understood how to work with the person to mitigate the known risk. For another person, their risk assessment stated that the person's memory had declined due to their dementia. However, there was no risk assessment in place to guide staff on how this may affect the person receiving their care or if there were any risks. Another person was a type one diabetic and was insulin dependent. The risk assessment noted that the person's insulin was managed by a district nurse and that the person should not eat foods containing sugar. However, it failed to provide any information on the symptoms of low or high blood sugar so that staff were aware of what to do if the person was experiencing low or high blood sugar levels. Where a person used a catheter, this had been identified but there was no guidance for staff on the associated risks, such as potential urinary tract infections, and how to mitigate the known risk.

Where people were bed bound and cared for in bed, there was a risk that people could develop pressure ulcers. One person that was bed bound received four care visits a day and also used incontinence pads. The risk assessment noted that the person required assistance but failed to state what assistance the person required and what staff should do to mitigate the risk. For another person, the risk assessment did state that they were at risk of pressure sores and that staff should apply cream regularly. However, there was no information on how staff could identify potential areas of the skin if a pressure sore was developing, such as redness or broken skin. Skin integrity had not been adequately recognised as a risk and there was no risk assessment in place to address this.

We raised this with the registered manager at the time of the inspection who told us that she would review the risk assessments and guidance provided to staff.

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

Staff that we spoke with knew people well and were able to explain the risks to the people that they were providing care to. Staff had regular people that they visited and told us that they got to know them and understood what their individual risks were.

Risk assessments also included an environmental assessment that looked at any areas of risk within the

person's home such as obstructions, security and kitchen appliances. These were detailed and ensured that staff understood any environmental risks. This was completed when a person was referred to the service as part of the pre-assessment visit by the service.

People and relatives told us that they felt safe when staff came to visit them in their homes to provide care. A person said, "Yes, definitely [safe]. They're really nice. I wouldn't swap her [staff] with anyone." Relatives commented, "She's 110 per cent safe. If my mum was unhappy she would tell them and me" and "Absolutely safe. No issues at all."

All staff members that we spoke with were able to explain how they would keep people safe and understood how to report it if they felt people were at risk of harm. Staff were able to explain different types of abuse and how to recognise it. One staff member told us safeguarding was, "About protecting vulnerable adults from abuse. If I notice anything that may be abuse I need to notify the office. I would contact the local authority and CQC as well if I needed to." Staff told us and records confirmed that they were trained in safeguarding adults during their induction and also received yearly refresher training.

Since registering with the Care Quality Commission (CQC) on 4 February 2015 the service had raised four safeguarding concerns to the local authority. We saw that the concerns had been investigated and resolved by the local authority. The service had documented internal investigations and liaised appropriately with the local safeguarding team to ensure that people were kept safe.

The service did not currently administer medicines to people receiving care and support. The majority of people using the service were supported by relatives with their medicines. The deputy manager told us, "We don't take clients we have to administer. The pharmacy or relatives fill their dosset boxes. We only prompt." There was a medicines policy that staff had access to. The medicines policy clearly stated the difference between administering and prompting people's medicines. Care workers that we spoke with understood the difference between prompting people with their medicines and administering medicines and confirmed that they did not administer medicines. Records showed that staff received medicines training in their induction and this was refreshed on a yearly basis.

The service ensured that people were protected by the control and prevention of infection. We saw that staff were provided with personal protective equipment (PPE) such as gloves and aprons. All PPE provided to each individual member of staff was signed out when it was collected from the office and stock levels monitored to ensure that staff were always able to access PPE.

The service followed safe recruitment practices. Staff files showed pre-employment checks such as two satisfactory references from their previous employer, photographic identification, an application form, a recent criminal records check and eligibility to work in the UK. However, for two staff there was an incomplete employment history. We raised this with the registered manager who was aware of the reasons for the gaps but had failed to document this.

There had been no accidents or incidents reported since registration with the CQC. We saw that there was a policy in place informing staff how to report any accidents or incidents. This was also covered in staff induction and staff that we spoke with were aware of how to report an accident or incident.

We looked at staff rotas and saw that staff were always assigned to the same clients. The field care supervisor told us that staffing arrangements for people was only changed in case of sickness or annual leave. People and relatives that we spoke with confirmed that they had the same care workers visiting them. A relative commented, "Yes, we have regular carers. My mum doesn't like a lot of strange people and she

likes regular carers, which is what she gets." Where the service ensured that the same care workers visited people this meant that there was a continuity of care and people got to know care workers and were able to build trust and rapport with them.

Good

Is the service effective?

Our findings

People and relatives told us that they thought the service met their needs. One person said, "They know me and what I like. They are very, very good with understanding me." People's needs were assessed when they were referred to the service. The registered manager told us, "We write the care plan from the referral paperwork. We go and do an assessment and confirm what the referral has told us." A tailored package of care was devised according to the outcome of the assessment. People's initial assessment included physical care needs, practical needs such as, washing and meal preparation and overall wellbeing.

People were supported by staff that were able to meet their needs. Staff told us and records confirmed they were supported through regular supervisions to look at people's on-going care needs and identify staff training and development needs.

Staff had a comprehensive induction when they started to work to ensure that they understood people's needs prior to working alone. There was a three day office based induction which introduced new staff to the values of the service and provided mandatory training such as health and safety, manual handling and safeguarding. Following the office based induction staff shadowed more senior staff when completing care visits. The deputy manager told us, "We plan it in a way that they shadow for three to four days, depending on previous experience. We inform the customer that a new person will be shadowing. When they are shadowing, they are there to observe. Just to see how the call is done." Following the shadowing, the staff member was reviewed, if further shadowing or training was required, this was provided.

All staff had received an annual appraisal. Staff had input into the appraisal process and had completed a self-appraisal prior to meeting with their line manager. Appraisals looked at what had gone well for staff over the past year and if there were areas that they wished to develop.

Staff training records showed when staff had completed training and when it needed to be renewed. All staff had received mandatory training in areas such as, manual handling, Mental Capacity Act 2005 and health and safety. All staff had been enrolled to complete the care certificate. The care certificate is a set of standards that care staff are expected to meet in order help them understand good care. The registered manager told us that all staff would complete this by December 2017.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Services providing domiciliary care are exempt from the Deprivation of Liberty Safeguards (DoLS) guidelines as care is provided within the person's own home. However, domiciliary care providers can apply for a 'judicial DoLS'. This is applied for through the Court of

Protection with the support of the person's local authority care team. There were no people using the service that were subject to a judicial DoLS. We checked whether the service was working within the principles of the MCA.

The service was not always working within the principles of the MCA. The service worked with some people living with dementia. However, people's capacity was not documented in their care files. Some care plans had been signed by the next of kin. However, there was no explanation documented why these had been signed by the next of kin and not the person receiving care. We spoke with the registered manger about this. The registered manager had a good understanding of the principles of the MCA but acknowledged that this had not been appropriately documented or implemented.

All staff had received training on the MCA and understood how this impacted on the people that they worked with. Staff told us, "It's [MCA] about clients who cannot make decisions and if they have capacity to make certain decisions. I always ask people what they want and give choice" and "Capacity can be anything that affects decision making, dementia, different stages of depression and so on. It is decisions specific. People may be able to make a decision in one area but not another." Another staff member commented that if they were aware that someone's capacity was changing and they were having trouble making decisions, they would contact the office to seek advice.

Staff were aware that they should report any changes in people's conditions to the office. On the day of the inspection we observed a member of staff coming into the office and reporting that a person that they had just visited had not been responding as they normally would. The staff member was advised to contact the person's GP to ensure their wellbeing. People and staff told us that the service did not usually attend healthcare appointments with people and that this was managed by relatives. However, the registered manager told us that if a person required support they would ensure that this was provided. For one person we saw that their care plan stated that staff would support them to attend appointments such as the GP, when requested. Relatives confirmed that the service supported accessing healthcare when they were asked to do so. One relative said, "If she needs to go to the doctors or something, they always arrange it for her." The registered manager told us, and we saw, that any healthcare visits were recorded in people's daily logs.

Care plans showed if people required help with meal preparation when care staff visited. People and relatives told us that where staff prepared meals, they offered choice and knew what they or their relative enjoyed eating. People told us, "I can cook for myself, she [care staff] warms it up for me. If I need to eat she will gently encourage me. She's very good" and "She makes me coffee and makes me a snack. She asks what I want." A staff member said, "We heat food up in the microwave. I don't impose my choice on anyone. They choose what they want to eat."

Records showed that people also received reviews form the local authority that placed them and the registered manager said, "Yes, the local authority review and we can also request if we think a review is needed." The registered manager was aware of the importance of working with the local authority for the best interests of the people that the service supported and ensuring the correct care for people's needs was provided.

Good

Is the service caring?

Our findings

We asked people and relatives if they felt that staff were caring. One person told us, "She is caring, very very much so. Whenever I open the door she gives me a smile and that is very very nice and I like her because anything I ask her to do, she will help me with. She's here a long time and I love her." Relatives commented, "Yes, absolutely [caring]. She's lovely, she properly looks after mum. Good as gold. They sit and chat to her when she's finished what she needs to do" and "The minute one girl comes through the door in the morning and evening mum lights up like a Christmas tree and she chats and chats to her and she [relative] smiles and giggles. The way they speak to my mum fills me with happiness. They're gentle and they never shout."

Staff had developed caring relationships with people. People and relatives were positive and told us that they valued the carers that visited. One person said, "Oh, they are wonderful, ever so nice and helpful." The service had received several compliments and thank you cards from relatives. One relative commented, "Thank you for your time and patience with me. Please give all the carers my love. It was a blessing to have had the services from them and you. If I hear of anyone in Enfield who needs a carer I would definitely recommend Redyfne."

We asked staff how they ensured that people were treated with dignity and respect. One staff member said, "All staff that we spoke with told us of the importance of ensuring people's dignity when they received personal care. This included keeping doors and curtains closed, asking the person if they were ready to have their personal care and allowing people to do as much for themselves as they were able to. A staff member said, "I make sure I give them dignity. If I am giving personal care I cover the part of the body while I wash other areas. I knock on the door before going in. I need to make sure that they feel comfortable."

Staff that we spoke with were positive about working with people with different faiths, cultures and sexualities. One staff member commented, "I need to respect the service users' culture. For example, if the service user is Muslim I know that they don't eat pork and I am aware of halal food. I don't discuss people's sexuality. I am there to care." Staff also gave us example of how they respected working in people's homes such as ensuring that if using a key-safe, that they called out a greeting before entering the persons home or using shoe protectors, to keep flooring clean and prevent infection, if people asked them to.

Care plans noted what people's faiths were so that staff were aware if there was anything that may relate to care being provided and a person's faith. The registered manager told us that families supported people with their faith.

Good

Is the service responsive?

Our findings

Care plans noted why the service was required and what care needs the person had. There was a section that noted how many care visits a day a person had and documented what care tasks staff should complete at each visit. However, care plans were inconsistent in the person centred information that they contained. For one person that required support with meal preparation, the care plan noted that the person 'liked cereal served with a cup of tea and prepare her a sandwich for lunch.' However, for other people their care plans noted that a meal needed to be prepared but failed to note the persons likes and dislikes around food. For another person, their care plan stated, 'transfer to the living room if required'. However, there was no information on how the person needed to be transferred or what type of support they required. For people that required prompting with medicines there was no information on how staff should prompt people. For example, a verbal reminder or showing a person where their medicines were.

When we spoke with staff, they told us that they always worked with the same people and were aware of their individual likes and dislikes. One staff member said, "I know exactly what she likes to eat and she will always tell me what she wants." A person said, "They know what I need." Staff were also able to explain how they prompted medicines for the people they were caring for.

Where people required help to access the community, we saw that this had been documented in their care plan. One person attended a day centre and needed to leave earlier in the morning. We saw that the care plan reflected that the person required an earlier care visit to ensure that they were ready on time to attend the day centre.

The registered manager told us that reviews of care plans were, "Once a year or if needs change." Relatives told us that they were involved in reviews of care. One relative said, "Yes, we were involved and just recently it was reviewed." We saw that where people's needs changed the care plan had been immediately updated. For example, one person had been admitted to hospital. Following their discharge home, their needs had changed and the care plan had been updated to reflect this.

The service had no documented complaints since it was registered with the CQC. There was a complaints policy which people were given when they began using the service. People and relatives told us that they knew how to make a complaint if they needed to. A person said, "Oh, I would just call them. They'd sort it out" Relatives said, "If there's any issues I always call [the registered manager] and she gets it sorted" and "Yes, I know how to complain if I need to."

Requires Improvement

Is the service well-led?

Our findings

At this inspection we found that there was a breach of the regulations regarding ensuring that risks were properly, assessed, minimised and documented. This issue had not been identified by the provider. We also found that information regarding people's ability to make decisions about their care was not documented in care plans in line with The Mental Capacity Act 2005 (MCA). Care plans were on the whole, person centred. However, there were examples when information about specific issues had been documented but there was no guidance for staff on how to ensure the person's requirements were met. This had not been identified by the provider.

Staff and relatives were positive about the registered manager. Staff said that there was an open culture at the service and they felt supported in their roles by the management team and registered manager. Staff commented, "She's [the registered manager] brilliant. She's a manager who listens. If we have any problems or concerns, she listens and acts" and "Yes, I am supported. She lets me get on but will help if I need it. She gives guidance and support." A relative said, "Yes, I know her well. She's lovely and does so much."

Staff received regular spot checks by the management team whist they were working in people's homes. Spot checks looked at various issues including how well staff communicated with people, that they were using gloves and aprons where appropriate, that staff arrived and left the call on time and that all care tasks required were completed. Where any issues were noted, this was documented and followed up with care workers. For example, for one staff member there had been an issue regarding accurate recording in the daily log for the person they were providing care to. The action noted was, 'Care worker to be immediately enrolled for record keeping course'. We checked the staff training record which showed that the care worker had received this training following the spot check.

We asked how the service monitored staff to ensure that they were on time for care visits and that they stayed the required amount of time. The registered manager told us that as well as the staff spot checks, "We call the customers. We pick those who specifically cannot call us and ask if the carer has been. People who are able will always call us, although this does not happen much." A relative said, "Our regular lady is rarely late. She is always on time. If she is going to be late she messages me." Rotas also showed that staff had enough travel time in-between care visits to ensure prompt arrival.

There were records of regular telephone monitoring. This was where office staff would contact people by phone and ask questions regarding the quality of the service that they were receiving. Where issues were identified the registered manager used these to make improvements to the service. Results were also discussed at team meetings if necessary. The service was in the process of completing surveys with people and relatives that used the service.

There had been three documented missed visits since April 2017. There were records of these missed visits and the registered manager told us that they had completed an investigation and taken appropriate action. However, the action taken had not been documented. We raised this with the registered manager at the time of the inspection. The registered manager acknowledged that that whilst the missed visits had been

addressed, this had not been documented appropriately.

We saw audits of daily log sheets. Log sheets are where staff document what has been done at care visits in the person's home. Log sheets were returned to the office monthly and audited each month. We looked at log sheets for nine people and saw that entries were detailed regarding care provided. The registered manager told us, and we saw that recording on log sheets was discussed at team meetings. The registered manager said, "We discuss log sheets in team meetings to ensure that they [staff] write legibly and shows a complete record of the care carried out for people."

There were regular staff meetings. This allowed the registered manager to provide staff with information about the service, reminders about best practice and for staff to raise any concerns or discuss ideas and feedback about the care they provided. One staff member said, "We are all free to ask questions."

The registered manager maintained an overview of supervisions that staff received and monitored when staff were due their supervision meetings. Staff were positive about the support that they received from management during their supervision.

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 Risk assessments failed to provide staff with guidance on how to mitigate people's known individual risks.