Routes Healthcare (North) Limited

Routes Healthcare Liverpool

Inspection report

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

We carried out an announced inspection of this service on 26 and 27 March 2018.

Routes Healthcare Liverpool is registered to provide personal care to people living in their own homes and communities. It is also registered to provide services for the treatment of disease, disorder and injury (TDDI). At the time of the inspection 21 people were receiving the regulated activity of personal care. At the time of the inspection Routes Healthcare Liverpool was not providing TDDI services.

A registered manager was 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.

The majority of people that we spoke with had no concerns about the safety of services. However, some people commented on the lack of consistency of staff and irregularity of call times. We made a recommendation regarding this.

Staff were safely recruited following the completion of appropriate checks. The service had recruited sufficient staff to ensure consistency for people receiving care.

People were protected from potential harm because staff knew them well and were trained to recognise signs of abuse or neglect.

The care files that we saw showed clear evidence that risk had been assessed and reviewed when people's needs changed. Risk assessments were sufficiently detailed and included guidance to reduce the level of risk.

Medicines were managed safely in accordance with relevant guidance. Staff were trained in the administration of medicines and had their competency assessed. Medicines' audits had been completed and had identified minor issues which had been corrected.

Staff had been trained to ensure that they had the rights skills and experience to meet people's needs. Staff told us they felt well-supported by the service and were given regular supervision. Annual appraisals were planned, but none of the staff had been employed for 12 months at the time of the inspection.

The service operated in accordance with the principles of the Mental Capacity Act 2005 (MCA). Where required, people's capacity was assessed in conjunction with families and professionals.

People's day-to-day health needs were met by the service in collaboration with families and healthcare professionals. Staff supported people with their healthcare needs and used information to update care

plans.

We did not have the opportunity to observe staff providing care as part of the inspection process. However, people told us that they very were happy with the quality of care and support provided.

Senior staff and managers were knowledgeable about each of the people that used the service and regularly worked along-side care staff. Care staff told us that they enjoyed providing support to people and were able to explain how they involved them in making decisions about their day-to-day care and support.

Staff respected people's right to privacy and were mindful of this when providing personal care. Staff explained the practical steps they took to respect people and maintain their dignity.

People and their relatives contributed to the assessment and planning process and were given choice over each aspect of their care. Care plans had been reviewed when people's needs changed and signed by the person or their representative. The care records that we saw were sufficiently detailed to instruct staff and contained person-centred information.

None of the people receiving care at the time of the inspection had specific needs in relation to equality and diversity. Relevant questions were asked during the assessment process to establish if people had any needs relating to equality and diversity which required specific consideration.

The service supported people with end of life care. We saw an example of an end of life care plan. However the plan did not contain detailed guidance for all aspects of end of life care. For example, in relation to pain management and the wishes of the person after their death. This was discussed with the provider.

People receiving care, their relatives and staff spoke positively about the management of the service and the approachability of senior staff. However, some people did say that communication could be improved. We discussed this with the registered manager.

The registered manager had completed a series of quality and safety audits on a regular basis. Audits processes included; spot-checks, weekly checklists and medication. We saw examples of where issues had been identified and corrected.

The registered manager was knowledgeable about their role and the organisation. Notifications to the CQC had been submitted as required. They were able to provide evidence to support the inspection process in a timely manner and facilitated contact with service users, family members and staff.

The staff that we spoke with were motivated to provide high quality care and understood what was expected of them. They spoke with enthusiasm about the people that they supported and their job roles.

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.

Call times were not always adhered to and staff were not deployed consistently in accordance with people's needs.

Staff were recruited following a robust process and were available in sufficient numbers to meet people's needs.

The care records that we saw showed evidence that risk had been assessed and reviewed.

Is the service effective?

Good

The service was effective.

Staff were required to complete a programme of basic training which covered a range of relevant topics. Staff said they were supported by the service.

People's day to day health needs were met by the services in collaboration with families and healthcare professionals.

Is the service caring?

Good

The service was caring.

People spoke positively about the attitude of staff and the quality of care provided.

Staff knew people well and told us that they enjoyed providing support to them.

People were afforded appropriate levels of privacy and supported to maintain their dignity at all times.

Is the service responsive?

Good

The service was responsive.

The service worked with people, their relatives and healthcare professionals to complete assessments and produce care plans

to a high standard.

People understood how to make a complaint although the majority of concerns were addressed informally.

Is the service well-led?

Good

The service was well-led.

The registered manager was well regarded by people receiving care and staff.

Audit processes were sufficiently robust to identify issues of concern.

Policies were reviewed to ensure they provided staff with accurate guidance.

Routes Healthcare Liverpool

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 26 March 2018 and was announced. Additional telephone calls were completed on the 27 March 2018. The inspection was announced because this is a small service and we wanted to make sure that people receiving care were notified and available to engage with the inspection process. This was the first inspection since the service was registered.

The inspection was conducted by an adult social care inspector.

Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the local authority who provided information. We used all of this information to plan how the inspection should be conducted.

A Provider Information Return (PIR) was not available for this service. A PIR 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. We took this into account when we inspected the service, and made the judgements in this report.

We spoke with three people who used the service, two relatives, three care staff, the registered manager, a care coordinator, an operations' manager and the quality and risk manager. We also spent time looking at records, including four care records, four staff files, staff training records, and other records relating to the management of the service. We contacted health and social care professionals who have involvement with

the service to ask for their views.

Requires Improvement

Is the service safe?

Our findings

The majority of people that we spoke with had no concerns about the safety of the care provided. However, some people commented on the lack of consistency of staff and irregularity of call times. Comments included; "I think it's safe" and "I've had teething troubles over times, but it's been resolved. There could be more consistency."

Staff were safely recruited following the completion of appropriate checks. Each staff file that we saw contained at least two satisfactory references, photographic identification and evidence of a recent Disclosure and Barring Service (DBS) check. DBS checks are used to help employers establish if applicants are suited to working with vulnerable people.

People told us that staff had arrived late to provide care which caused them concern. People said that they were usually made aware that staff were running late, but not always. Some people reported that the lack of consistency in call times had a negative impact on their health and wellbeing. We spoke with the registered manager and a care coordinator about this. They acknowledged that staffing issues had impacted on call times and the availability of regular staff in the recent past. Staff sickness and a relatively high turnover of staff were cited as contributing factors. They provided evidence that they had recently recruited sufficient staff to meet people's needs. They also outlined their intention to review the allocation of staff and consider the purchase of an electronic call monitoring system to ensure that issues of a similar nature were identified and rectified at an earlier stage.

We recommend the provider reviews its procedure for call monitoring to ensure that people receive safe, effective care.

People were protected from potential harm because staff knew people well and were trained to recognise signs of abuse or neglect. Staff had completed training regarding adult safeguarding procedures. The staff that we spoke with confirmed that they had attended the training and were able to explain the different types of abuse and what action they would take if they were concerned that abuse or neglect were taking place. The provider had a range of systems and procedures in place which allowed people using the services, their relatives and staff to raise any concerns. There had been one safeguarding referral made in the previous 12 months. This had been completed in accordance with the relevant policy and procedure.

The care files that we saw showed clear evidence that risk had been assessed and reviewed when people's needs changed. Risk assessments were sufficiently detailed and included guidance to reduce the level of risk. We saw evidence of risk assessments in relation to; the environment, moving and handling and skin integrity. Where significant risk was identified additional resources were deployed. For example, when skin integrity was of sufficient concern, staff were required to complete a body map to assist in monitoring.

The provider's approach to whistleblowing was detailed in the relevant policy. The policy contained details of organisations that could process whistleblowing concerns and advise staff. Staff were able to explain internal mechanisms for reporting concerns and were aware of the external resources available to them if

required. Each of the staff that we spoke with expressed confidence in internal reporting mechanisms.

Staff were provided with basic training and personal protective equipment (PPE) to help protect people from the risk of infection. Staff understood the importance of using PPE when providing personal care.

Staff were trained in the administration of medicines and had their competency assessed, but because care was provided in people's homes, they were not always responsible for the storage and administration of medicines. Some people who used the service were able to self-administer their medicines; others received support from a relative. At the time of the inspection staff were not supporting people with their medicines. However, we were able to access some medicines administration records (MAR) sheets which had been completed correctly. We also spoke with the quality and risk manager who confirmed that medicines were administered in accordance with best-practice and the relevant policy. The medicines policy provided clear guidance regarding; storage administration, record-keeping, covert medicines, topical medicines and PRN (as required) medicines. Medicines' audits had been completed and had identified minor issues which had been corrected.

Incidents and accidents were recorded on an electronic system and subject to analysis by the registered manager and the quality and risk manager. There had been a small number of incidents or accidents since the service became registered. They had been recorded in detail and analysed to look for patterns and trends. Accidents and incidents were discussed at team meetings and used to improve safety and quality.

Good

Is the service effective?

Our findings

Staff were trained to ensure that they had the rights skills and experience to meet people's needs. People receiving care and their relatives confirmed this. Comments included; "They're well-trained and very caring", "They have the right skills" and "My main carer is called [name] and is brilliant."

Staff were trained in a range of subjects which were relevant to the needs of the people using the service. Subjects included; safeguarding adults, moving and handling, administration of medication, Mental Capacity Act 2005 and equality and diversity. We looked at records relating to training and saw that the majority of training had been completed in accordance with the provider's schedule. Staff with less than six months' experience were inducted in accordance with the principles of the Care Certificate. The Care Certificate requires staff to complete a programme of learning and have their competency assessed before working independently. The registered manager and care coordinator regularly worked along-side new staff and assessed their competency.

Staff told us they felt well-supported by the service and were given regular supervision. Annual appraisals were planned, but none of the staff had been employed for 12 months at the time of the inspection. Policies, procedures and other documents intended to guide staff made appropriate reference to legislation and standards including National Institute for Health and Care Excellence (NICE) guidance and the Care Quality Commission's fundamental standards. However, some information was out of date. This was corrected following the inspection.

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. People's capacity was assessed in conjunction with families and professionals. None of the people currently using the service were subject to restrictions on their liberty. However, staff were aware of the need to seek authorisation from the Court of Protection if people's liberty needed to be restricted to keep them safe.

Staff helped some people to prepare and eat nutritious meals as required by their plan of care. The majority people receiving care at the time of the inspection were able to prepare their meals independently or had a relative to do this for them. However, there were occasions when staff were required to assist. The staff that we spoke with were clear about their responsibilities in relation to this aspect of care and had access to instructions in the person's home.

People's day-to-day health needs were met by the service in collaboration with families and healthcare professionals. Staff supported people with their healthcare needs and used information to update care plans. We saw evidence in care records that staff supported people to engage with community and specialist healthcare organisations. For example, district nurses, GP's and hospital' services.

Good

Is the service caring?

Our findings

We did not have the opportunity to observe staff providing care as part of the inspection process. However, people told us that they very were happy with the quality of care and support provided. People told us; "They have a good manner and take a personal interest in [relative]. They treat [relative] with respect", "I've got used to all the staff. They're lovely. Without exception, they're all very caring" and "I've found Routes (Healthcare Liverpool) to be very caring with empathy."

Senior staff and managers were knowledgeable about each of the people that used the service and sometimes worked along-side care staff. People receiving care had regular contact with the registered manager and care coordinators and were able to contact them using an on-call number if necessary. This meant that the management team were able to monitor the quality of care through a variety of means.

Staff told us that they enjoyed providing support to people and were able to explain how they involved people in making decisions about their day-to-day care and support. It was clear from discussions that care staff knew the people they supported well. When we spoke with them they described the person and their needs in detailed, positive terms. Where people had difficulty communicating their needs and preferences, staff had additional guidance to support them. For example, one care record explained how the person did not use speech, but could understand what was being said to them. The person was able to make their views known through facial expressions and body language.

People and their relatives were clear that they had choices regarding how and when support was given. For example, staff described in detail how one person sometimes chose to spend their time talking with them rather than receiving care and support as directed by their care plan. Staff explained the potential impact of this decision to the person and ensured that sufficient time was allowed to meet their basic needs.

None of the people we spoke with at the time of the inspection was accessing independent advocacy although they were aware that it was available to them.

Because of the nature of people's care needs, there were limited opportunities to promote people's independence. However, staff explained how they had sufficient time to encourage people to do things for themselves. For example, dressing and washing certain parts of their body.

We asked people about the need to respect privacy and dignity. People told us that staff respected their right to privacy and were mindful of this when providing personal care. Staff explained the practical steps they took to respect people and maintain their dignity when providing personal care. For example, covering people with a towel when washing them. A member of staff told us, "You get to know the person and build trust. We always talk to people throughout [personal care tasks]. It's about their dignity."

Good

Is the service responsive?

Our findings

We saw from care records that people and their relatives contributed to the assessment and planning process and were given choice over each aspect of their care. Care plans had been reviewed when people's needs changed and signed by the person or their representative. Each of the people that we spoke with confirmed that they were fully involved in discussions and the review of their care and support needs. One relative told us, "I was involved in the care plans and risk assessments." With reference to the assessment and planning process, another relative said, "I do feel they listened. Only Routes have ever listened to me."

Qualified nurses completed a comprehensive assessment before the service started. The information was used to produce initial care plans for the first seven days of care. A more detailed care plan was then produced for the next six months and scheduled for review after 12 months or as people's needs changed.

The care records that we saw were sufficiently detailed to instruct staff and contained person-centred information. In one record there was a good level of detail about; family history, life history, medical history, likes and dislikes. This helped staff to get to know the person and provide individualised care which was responsive to the person's needs. One care record relating to a person with complex healthcare needs provided detailed guidance for staff, but also focussed on their personal preferences. For example, the record stated, '[Name] enjoys going out for walks, the feeling of fresh air and rain on [their] face.' This meant that staff had sufficient information to get to know the person and not just their healthcare needs.

None of the people receiving care at the time of the inspection had specific needs in relation to equality and diversity. Relevant questions were asked during the assessment process to establish if people had any needs relating to equality and diversity which required specific consideration.

Because of the nature of the care provided there were limited opportunities to engage people in activities. However, care records contained information on people's likes and dislikes that staff used in conversation as they provided care.

The service had received one formal complaint in the previous 12 months. This was being addressed at the time of the inspection. We spoke with the person who had made the complaint and they told us that they were satisfied with the response received so far. People and their relatives were given information about making a complaint when their service started. The complaints procedure was clear and detailed and provided information on how to complain to an external body such as the local authority or the Care Quality Commission.

The service supported people with end of life care. We saw an example of an end of life care plan. However the plan did not contain detailed guidance for all aspects of end of life care. For example, in relation to pain management and the wishes of the person after their death. We spoke with a care coordinator about this. They explained that two new care plans were being introduced which would provide the level of detail required. End of life care had been discussed with staff at a recent team meeting.

Good

Is the service well-led?

Our findings

A registered manager was in post. They were part of an extensive management structure which included; care coordinators, an operations manager and a quality and risk manager. The governance structure was clear and appropriate for the size of the service. Each of the people we spoke with understood their role and responsibilities within the structure.

People receiving care, their relatives and staff spoke positively about the management of the service and the approachability of senior staff. However, some people did say that communication could be improved in some respects. For example, in relation to delays in carer arrivals. Comments included; "It's just the communication issue. That's the biggest", "They [managers] are approachable. I'm quite happy" and "Of all of the care companies I've had, they're the best. They're so willing to get it right."

The registered manager had completed a series of quality and safety audits on a regular basis. Audits processes included; spot-checks, weekly checklists and medication. We saw where issues had been identified and corrected. For example, missed signatures and the use of blue ink on MAR sheets. Concerns relating to late calls had been identified and had resulted in changes to improve performance. At the time of the inspection it was too early to demonstrate what impact the changes had.

The registered manager was aware of the day to day culture and issues within the service. We saw that they knew the people using the service and their staff well. The registered manager regularly worked along-side staff as a carer and provided additional support. One person told us, "The manager came out and worked along-side staff and did my shopping for me."

The registered manager was able to articulate a clear vision for the service which maintained its focus on high-quality, individualised care. This was supported by the other managers and senior staff that we spoke with and reflected in promotional materials.

The staff that we spoke with were motivated to provide high quality care and understood what was expected of them. They spoke with enthusiasm about the people that they supported and their job roles. Each of the staff was positive about the support and quality of care offered by the organisation. Clear guidance for staff was available through a comprehensive set of policies and procedures. However, some information in policies was incomplete or out of date. For example, the safeguarding policy contained contact details for a number of local authorities, but not the one where the location was based. The complaint's policy contained out of date information about CQC's assessment framework. This meant that staff may not have had immediate access to accurate, relevant information. We discussed this with the provider who supplied evidence that the policies had been reviewed and amended.

The registered manager and provider engaged with staff through a variety of methods. Staff had access to a secure electronic portal for important information. They also had regular team meetings where important updates and incidents were discussed. Information and lessons learnt from other branches were also used to improve practice.

People using the service and their relatives were contacted by telephone and also asked to complete quality assurance questionnaires. Feedback was used to improve safety and quality. For example, in relation to the consistency of staffing and call times.

The registered manager was knowledgeable about their role and the organisation. Notifications to the CQC had been submitted as required. They were able to provide evidence to support the inspection process in a timely manner and facilitated contact with service users, family members and staff.