Renaissance Care Services Limited

Renai Support Services

Inspection report

Farmhouse Business Centre
East Budleigh
Budleigh Salterton
Devon
EX9 7BY

Tel: 07717796396
Website: www.renaissancecareservices.co.uk

Date of inspection visit:
04 September 2018
11 September 2018

Date of publication:
19 October 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Renai Support Services provides personal care and support to people living in supported living in Torquay and East Devon. Supported living is defined as situations where people live in their own home and receive care and/or support which helps to promote their independence. At the time of our inspection, personal care and support was being provided to four people living in one house in Torquay. The personal care provided to people was 24-hour support with a set number of hours per week allocated as one-to-one care.

Renai Support Services also provides enablement support to other people living in the same house and elsewhere. The Care Quality Commission (CQC) is only authorised to inspect the personal care services provided. The inspection therefore did not look at the care provided to people who received enablement.

Rating at last inspection
At our last inspection we rated the service as Good. At this inspection we found the evidence continued to support the rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Why the service is rated Good
People were supported by caring staff who understood the care each person required to ensure they were kept safe. People's care needs had been assessed when they first received care from Renai staff; care plans were reviewed regularly and involved the person and their family. Where risks, needs or preferences changed, care plans were amended to ensure the care was still safe and maintained people's quality of life.

Staff showed genuine care and compassion when working with people. People and their families were very positive about the care provided. Staff supported people to be as independent as possible by doing activities both inside and outside the home. Staff also supported people's rights to privacy, dignity and family life. Staff worked within the requirements of the Mental Capacity Act 2005.

There were sufficient staff to help people receive care in a relaxed and calming environment. Staff spent time understanding and delivering care to people, some of whom were not able to communicate verbally. Staff were able to describe, and demonstrate, how they used a variety of communication methods which were tailored to each person's requirements.

People were helped to stay healthy and well. Staff supported people to have a healthy diet and ensured, where necessary, health professionals were consulted and involved in the person's care.

Staff were recruited and trained to ensure the care provided was safe. Training included how to support people with specific conditions such as epilepsy. Staff were also supervised and supported by the registered manager.

Medicines were received, stored, administered and recorded following national good guidance and practice.

The registered manager was also a director of the provider organisation. They understood their role and worked with people, family and staff to consider and implement improvements to the service. This included considering lessons that could be learned when things went wrong. There was a complaints policy and procedure which supported people and their families to raise concerns. The service had met the requirements of the Health and Social Care Act 2008 by submitting information when requested to the Care Quality Commission and displaying their last inspection rating.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Renai Support Services

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 a comprehensive inspection carried out by one adult social care inspector on 4 and 11 September 2018. We notified the provider we would be carrying out the inspection 24 hours before the first day of inspection. We gave the service notice of the inspection visit because the location provides a domiciliary care service for younger adults who are often out during the day. We needed to be sure that they would be in.
Prior to the inspection we reviewed information we held on our systems about the service. This included the Provider Information Record (PIR). The PIR is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We also looked at statutory notifications sent in by the service. A statutory notification contains information about significant events, which the provider is required to send to us by law.

During the inspection, we met all the people receiving personal care from the provider and spoke with one of them. We were not able to speak to others receiving personal care as they did not have verbal communication skills. However, we spent time with them in communal areas observing the care they received. We also spoke with one relative by phone to gather their views about the care provided to their family member.

We met and spoke with the registered manager and four staff during the inspection. We reviewed care records, medicine administration records and the daily notes for the four people receiving personal care. We also reviewed other records relating to the running of the service, including staff rotas, training records, minutes of meetings and quality monitoring records.

After the inspection we spoke with two relatives. We also contacted a health and social care team who support people and two health professionals. We received feedback from two of professionals.

Good

Is the service safe?

Our findings

People continued to receive safe care. People were kept safe as there were systems and processes which staff understood and followed. These included what to do if staff were concerned that a person was being abused.

People looked relaxed and happy. Feedback from families showed they thought their relavtive was looked after safely. For example, one relative said "They are looked after by staff it feels really safe."

Risks to people had been assessed and documented in their care plans. The care plans included information about what staff should do to support people to minimise those risks while supporting people to remain as independent as possible. For example, one person who used a wheelchair was being supported to become mobile independently. Risk assessments had been undertaken about how this should be done and what support was required from health professionals and staff.

The registered manager considered people's needs and the activities they were planning to do each day. This helped the registered manager identify the number of staff needed to support people safely at different times of the day and night. For example, staffing levels were increased when some people went out to ensure they had two staff to support them in the activities they were doing. Staff said they felt there were sufficient staff on duty which meant that they did not have to rush people. Staff were observed spending time with people, helping them in a calm, unhurried way.

Staff had been recruited safely as the registered manager said, and records confirmed, that checks had been carried out to make sure they were suitable to work with vulnerable people. Before someone started working at the home, they would be interviewed and, if found suitable, offered a post subject to satisfactory background checks. These checks included references from previous employers and a Disclosure Barring Service (DBS) check. The DBS is a criminal records check which helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

One person was involved in recruiting prospective members of staff; they did this by showing the candidate around the house and sharing photos of activities they did. The registered manager said feedback from the person helped to inform the decision about offering the candidate an opportunity to work with Renai Services.

Medicines were received, stored, administered and documented in a safe manner. Staff had been trained to administer medicines and followed the procedures when doing this. The registered manager carried out audits of medicines regularly. Where any issues were identified, action was taken to address the issues and reduce the risks of reoccurrence.

People were protected by staff to help prevent the spread of infection. Staff used appropriate personal protective equipment including disposable gloves and aprons when carrying out personal care. Staff also

were seen to complete good hand hygiene practice before preparing food.

The registered manager and staff analysed what had happened when things went wrong. They had considered any issues which led up to the incident, what had happened at the time and afterwards. They also looked at what could have been done differently which might have reduced the risks. This meant that there was a culture of improvement which helped to reduce the risks of a reoccurrence.

Good

Is the service effective?

Our findings

The service continued to be effective. The service was meeting the needs of people with a learning disability as it was supporting people in line with the recommendations in national guidance, including Registering the Right Support. These values include choice, promotion of independence and inclusion. People supported by Renai Support Services were enabled, as far as possible, to live as ordinary a life as any citizen.

People's physical, mental and social needs had been assessed holistically when they started receiving support from the service. Where their needs had changed, the service had also reviewed the risks and the associated care plans to ensure they continued to deliver effective care.

The care plans described the person's background and history as well as other key information needed to provide good care. For example, one care plan described what a good day was like for the person, including what time they liked to get up, activities they enjoy and how to recognise different moods. Each care record contained a document called "My support plan in brief", which highlighted key risks, needs and preferences. For example, one person was described as "I drink normal fluids; I have a good appetite; I wear glasses all the time; I like to wear jewellery." This helped staff to have a quick and easy way to check how the person needed to be supported. One member of staff described how useful it was if they hadn't supported the person before. They said, "It is a good reminder of how each person likes their care to be given." Daily notes detailed the care people received, which reflected the care described in the care plans.

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 worked with people to ensure they promoted people's rights to independence while working in the person's best interests. Care records contained information about how best interests' meetings and decisions had involved the person, health and social care professionals, staff and, where appropriate, families. For example, decisions were recorded about whether a person should have blood taken for a particular test. A health professional commented "Staff are proactive about asking for advice. This has included meeting with me, family and staff around [person's] best interest."

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this are called the Deprivation of Liberty Safeguards (DoLS). It is the responsibility of the local authority to apply for a community DoLS to the Court of Protection for a person, where they are living in supported living accommodation. However, staff, who support the person with personal care, need to be aware of the DoLS and any conditions associated with the DoLS. We found the manager was aware of the requirements of the MCA, although no-one at the time had a DoLS authorisation in place. The registered manager was working with a community professional who was reviewing whether a DoLS for a person

should be applied for.

Staff were supported to have the necessary skills and knowledge to deliver effective care and support. Staff completed an induction when they first joined Renai and were also expected to refresh their training at regular intervals. This helped them to remain aware of current best practice and legislation. New staff, who had not worked in a care setting before were expecting to complete the Care Certificate during their induction. The Care Certificate is a national set of minimum standards designed by Skills for Care for social care and health workers that should be covered as part of induction training of new care workers. Staff were also supported as they receive regular supervision and annual appraisals. Supervision provides an opportunity for staff to reflect on their performance and identify any training needs they might have.

People were supported to have sufficient to eat and drink to help ensure they maintained a balanced diet of their choice. For example, staff described how one person really enjoyed salad. Staff prepared a side salad for them to have at lunchtime alongside their sandwich, which the person clearly enjoyed.

One person was keen to lose some weight and staff were supporting them with this goal. They did this by offering low fat alternatives and encouraging the person with their diet. Where people were at risk of choking, staff ensured the food was prepared correctly and helped them to eat. Staff watched for signs that the person had finished each mouthful before giving them more food. Some people could prepare drinks with staff support, which they were encouraged to do throughout the day. Where people were not able to do this, staff ensured they were offered, and given drinks, of their choice.

Staff worked with health professionals to enable people to maintain good health. Staff contacted health professionals appropriately to ensure people's physical and mental health needs were met. This included their GP as well as specialists such as speech and language therapists and learning disability professionals. A relative commented "[Person] now never gets sore, which is amazing as before they had Renai, it was always happening."

Good

Is the service caring?

Our findings

The service continued to be caring. Throughout the inspection, we observed staff supporting people with kindness, respect and compassion. One person, who could communicate verbally, said they really liked the registered manager and staff. Other people appeared relaxed and comfortable with staff, often showing this by giving staff a hug. Staff were observed laughing and joking with people, as well as asking them about their day and what they would like to do.

Staff described how each person had different routines and needs. For example, staff helped one person who did not have verbal communication to eat at lunchtime. The member of staff sat so they had good eye contact and could talk to the person while feeding them. The member of staff described what the food was, for example, say "Here's some sweet potato and cabbage -you like cabbage don't you?" The staff member watched for signs the person had finished each mouthful before offering more. When the person had difficulties swallowing, another member of staff also came to help and offer support, for example holding and stroking the person's hand gently.

Staff supported people to express their views and make decisions about their care and support. For example, one person's care records described how they were able to make decisions about what they wanted to wear each day. It also described the activities they enjoyed.

Each person had a key worker who supported them to review, as far as possible, their care plan each month. This meant people were encouraged to actively choose what they did and where they went. One person had said they no longer wished to attend an activity in the local community. However, staff recognised that they might change their mind and therefore would ask the person if they had, and if not, what else they might like to do.

Staff understood the importance of people's rights to a family life. People were encouraged to keep in contact with their family and friends. This included face to face contact and via social media. A relative commented "Been there all times of day and night, amazing care." Another relative commented they were "made to feel very welcome." Staff had taken time to find out about people's background and involve family so they understood more about the person. For example, a relative commented "Really hear what I say and ask for info about his life before." Another said, "We are very pleased, no worries at all." A health professional commented "Carers are friendly and helpful."

Staff were mindful of people's rights to privacy and dignity. Staff said one person liked to sometimes spend time in their bedroom. Staff offered the person the opportunity to go to their bedroom for a rest when they appeared tired after lunch. The person said they would like to do this, so staff helped them to go there, talking to the person about what they might do later and supporting them to walk slowly.

Staff knocked on people's bedroom doors before entering and ensured that doors were closed before supporting them with personal care.

Good

Is the service responsive?

Our findings

The service was extremely responsive to people's needs, using innovative, individualised ways to involve and consult with people and their families about their care. This included helping people achieve a life which was as ordinary a life as any citizen.

Each person had a personalised care plan, which contained risk and needs assessments and information about people's preferences and aspirations. People, and their families, were fully involved both when they first received support and at regular intervals. One relative said "Staff 'bend over backwards'…they really involve and consult with me." Care was also reviewed when a person's risks, needs or preferences changed. These changes were documented in the person's care plan.

Staff meetings, including hand-over meetings between shifts, ensured that staff were made aware of changes. Staff also said they discussed in detail a person's care plan at meetings regularly, which helped them to think about how they were working with the person currently and whether there may be different, better ways to do so. This meant that staff were putting the person at the heart of the care delivered.

Care plans included information which was important for staff to know. This included things that were important to the person on a day-to-day basis as well as in the longer term. A relative said that registered manager had discussed with them, their family member's end of life plans. The relative said "this assured me [person] will stay on and they will be able to support him at the end of his life." They described how pleased they were about this as they felt that would be the right way for the person to receive good end of life care with people around who knew them. Another relative commented how the service had "sorted out [person's] finances, which was brilliant." They added that this had not been something they felt able to do, so were very pleased not to have this burden.

Care plans described a really responsive approach to delivering care, including how it met people's current and longer-term aspirations. The approach was reflected in the way care was designed and delivered with people at the heart of how this was achieved. For example, one person's care plan described how they enjoyed spending time in the community, attending a day centre, going shopping and out for social occasions. It also described domestic tasks they could complete, and the support required, such as washing, dressing, laundry and cooking. The activities all enabled the person to live as independently as possible within their community, playing an active and vibrant role inside and outside the home.

A relative commented "Can't fault it, had doubts before [person] moved there as they lived at home and you hear stories, but I couldn't have been more wrong. Person has blossomed so much and gained independence, which is wonderful to see… come on leaps and bounds."

The service was committed to using an approach which put each person at the centre of their care. The staff encouraged people to value themselves and others. People's talents were recognised and celebrated. This positivity helped people to achieve their goals and aspirations. For example, one person was being encouraged to undertake physical exercise as they wanted to be able to take an active part in a family

celebration. A relative commented "They really help in so many ways and show such care, thinking about what the person might want and then sorting it." They also described how staff had researched and sourced equipment to help them. The relative said "They have got [person] equipment which I have never heard of and it is amazing. They involve me in everything, I never feel I miss out, I even join in [activity]."

People were supported to follow their own interests. For example, one person had expressed a wish to work in a catering setting. To enable this, staff had supported them to attend a catering course at a local activity centre.

Staff recognised the characteristics of each person including their age, gender and abilities. This meant that staff supported each person taking this into account, for example their preferences around TV, music and food. People were supported to follow a religion of their choice if they expressed a preference.

From April 2016 all organisations that provide NHS or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively.

People's communication needs and abilities were documented in their care plans. Where people had limited ability to communicate verbally, there were details of their preferred methods of communication. Staff were able to describe each person's methods of communicating. This included staff recognising people's facial expressions and body language, as well as sounds they were able to make. People's communication was supported by a variety of methods, including the use of new technology. For example, we observed numerous occasions during the inspection, where one person communicated with the registered manager and staff via mobile text messages. Staff said the person found this an effective way to communicate their preferences about their care, even if they were in the same room as the person. The person sent messages about what they wanted to do, asked questions about which member of staff supported them as well as responding to questions from staff who would text back.

People's health needs were considered when planning the support they needed. This included both the person's physical and mental health. Where changes to a person's health were identified staff took action to investigate and respond to the changes. For example, where staff had identified concerns about a person's memory, they had involved health professionals including the person's GP. Guidance about people living with both a learning disability and dementia helped staff to support people using the service and respond to changes in their presentation. A health professional commented "Staff want to be involved and joined up with us."

Where people, or their families, had concerns or complaints, there were procedures in place for these to be dealt with. There had been no formal complaints since the previous inspection. One person was able to say they had no complaints. A family member said that they had had a concern about the care their relative had received. However, they also said they had raised this with the registered manager, who had responded positively and ensured that improvements were put place. They said they felt the registered manager had listened to them and acted appropriately. They added that they were aware of how to raise a complaint formally but had not had the need to.

Good

Is the service well-led?

Our findings

The service continued to be well-led by a registered manager who was also one of the directors from the provider organisation. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager understood their role, which included providing information to the CQC when necessary. For example, the registered manager had submitted a provider information return (PIR) in March 2018, which described the service, what it did well and what improvements were planned. The registered manager had also submitted statutory notifications to the CQC when necessary. For example, when a person had been injured or abuse was suspected. The registered manager had worked with health and social care professionals as well as the CQC to reduce the risks of reoccurrence. The provider's website displayed the current rating of the service as required by the CQC.

At the end of 2017, the registered manager had delegated some responsibilities to a senior member of staff. However, the registered manager said this had not been successful and therefore they had reviewed the situation and taken action to address the issues. The registered manager said they had recently appointed a new member of staff, who was yet to take up post. The intention was that this person would eventually take over the day to day running and register as the manager with the CQC. The registered manager said they would continue to ensure the quality and safety of the service through regular meetings with the new appointee. This showed the registered manager had a clear succession plan and longer-term strategy for the service.

The providers had a clear vision of the support and care Renai offered to people. People, their families and staff were involved in ensuring that the care delivered was person centred and empowering. People, families and staff all said they liked the registered manager. They said she was very supportive and provided helpful guidance. Regular staff meetings helped to ensure the communications between the registered manager and staff were maintained.

There were effective quality assurance systems in place. These systems helped to ensure that people were receiving safe and effective care from staff who understood and were supported to meet people's needs. Checks were carried out to ensure the supported living environment was safe and of good quality. Where issues were identified, there were systems to communicate these to the provider of the accommodation. There were regular audits of care records and other documentation relating to people's care, such as medicine administration records. Where issues were identified, action was taken.

The registered manager looked at ways to improve the service, by getting feedback from people, their families and professionals. The registered manager kept abreast of current and upcoming legislation and guidance. They used this to help improve the care provided by Renai.