G P Homecare Limited

Radis Community Care (Poppyfields)

Inspection report

Poppyfields
Chapman Way, Eynesbury
St Neots
Cambridgeshire
PE19 2PF

Tel: 07834804699
Website: www.radis.co.uk

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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 service provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

People using Radis Community Care (Poppyfields) live in one building, called Poppyfields. There are 34 one or two-bedroom flats each with their own front door onto shared corridors, spread over three floors. There are other shared facilities such as lounges, assisted bathrooms, a hairdressing salon and a dining room where the housing provider offers people a three-course cooked lunch. Radis Community Care (Poppyfields) has an office on the ground floor, as does the manager who works for the housing provider.

Not everyone living at Poppyfields receives a service from Radis Community Care (Poppyfields). CQC only inspects the service being received by people provided with the regulated activity 'personal care'; help with tasks related to personal hygiene and eating. Where people do receive personal care we also take into account any wider social care provided.

This is the first inspection of this service since it was taken over by G P Homecare Limited in April 2017.

The inspection visits to the service's office took place on 13 February 2018 and 14 March 2018. Both visits were announced. For the first visit we gave the service 24 hours' notice as we needed to be sure that there would be someone in the office. As the registered manager was not available on 13 February, we arranged a second date so that we could speak with the registered manager and conclude the inspection visits. Following this we gave the new management team five days to get any further information to us.

There was a registered manager in post on 13 February 2018 but they were on leave. 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 registered manager resigned their employment with G P Homecare Limited before our second inspection visit. On 14 March 2018 we met with the area manager and a registered manager who managed two of the provider's other extra care housing schemes.

People felt safe and were protected as far as possible by staff who were competent to recognise and report any avoidable harm or abuse. Potential risks to people had been assessed and measures put in place to minimise the risks.

There were enough staff to make sure that people were safe and their needs met in a timely manner. The provider's recruitment process reduced the risk of unsuitable staff being employed. Staff followed the

correct procedures to prevent the spread of infection and understood their responsibility to report any accidents and incidents.

Errors in recording meant that we could not be sure that people were given their medicines safely and as they had been prescribed.

Assessments of people's needs were carried out to ensure that the service could meet those needs in the way the person preferred. Technology such as alarm call system was used to enhance the care being provided.

Staff received induction, training and support to enable them to do their job well. Further training in topics relevant to individual people's care was needed so that staff would feel fully competent. When required, staff assisted people with their breakfast and a light evening. The housing provider supplied a three-course lunch in the dining room. Staff involved other healthcare professionals such as GPs in people's care if the person needed assistance with this.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

People and their relatives made positive comments about the staff. Staff treated people kindly and showed they knew each person well. People were involved in planning their care and support. Staff respected people's privacy and dignity and supported people to remain as independent as possible.

Care plans gave staff detailed guidance relating to the care and support each person needed so that people received personalised care that was responsive to their individual needs.

A complaints process was in place and a complaint had been dealt with in a timely manner. The provider had a process in place to meet people's end-of-life care needs when this was required.

Staff felt supported by the team leader and area manager even though the registered manager had not provided good leadership. Staff were clear about their role to provide people with a high quality service, thus upholding the values of the service. Staff liked working for this service.

A quality assurance system was in place, including a number of ways in which people, their relatives and staff were enabled to give their views about the service and how it could be improved. Audits and monitoring checks on various aspects of the service, including spot-checks on the way staff worked with people, were carried out. These had not always ensured that any shortfalls were addressed.

The area manager was aware of the various matters that the service was required by law to notify CQC about. The service worked in partnership with other professionals to ensure that joined-up care was provided to people.

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.

We could not be sure that medicines were managed safely nor that people were given their medicines as they had been prescribed.

There were enough staff deployed to keep people safe and meet their needs. Staff recruitment reduced the risk of unsuitable staff being employed.

People were protected from avoidable harm by a staff team trained and confident to recognise and report any concerns. Potential risks to people were assessed and minimised.

Is the service effective?

Good

The service was effective.

Staff had received training so that they had the skills and knowledge to deliver care to people. They needed further training in specific areas relevant to individuals.

Staff worked within the principles of the Mental Capacity Act so that people's rights in this area were protected.

Assessments of people's needs were undertaken. Technology was used to enhance the care provided.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff who knew each person and their individual needs well.

People were fully involved in planning their care and support. Staff showed they cared about the people they were providing a service to.

Staff respected people's privacy and dignity and encouraged people to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

Care plans were in place for each person and the care was personalised to meet individual needs.

Complaints and concerns were responded to.

A process was in place to ensure that people's end-of-life care needs would be met when this was required.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager did not always provide good leadership.

Audits and quality monitoring checks were carried out but identified shortfalls had not always been addressed.

The quality assurance process gave people, their relatives, staff and other stakeholders a number of ways in which to comment about the service.

Radis Community Care (Poppyfields)

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 the first inspection of this service since GP Homecare Limited took over as the provider in April 2017.

Our inspection activity started on 13 February 2018 and ended on 19 March 2018. It included two visits to the provider's office. The first visit on 13 February 2018 and was carried out by an inspector, an inspection manager and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. This expert-by-experience had experience of caring for someone who used a wide range of health and social care services. Our second site visit was on 14 March 2018 and was carried out by the inspector and the inspection manager. The inspection visits were announced. We gave the service 24 hours' notice of the first visit to the office because we needed to be sure that someone was available.

Prior to the first inspection visit we looked at information we held about the service and used this information as part of our inspection planning. The information included notifications. Notifications are information on important events that happen in the service that the provider is required by law to notify us about. In January 2018 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. We used this information to assist with planning the inspection.

We spoke with five people who were receiving the service and we spoke over the telephone with the relative of one person who was using the service. We spoke with one team leader, two care workers, the area

manager and the registered manager who managed two of the provider's other extra care housing schemes. We looked at two people's care records as well as other records relating to the management of the service. These included medicine administration charts, audit records, the service development plan and the complaints folder. We wrote to three sets of health/social care professionals who the service told us had regular contact with the service. Two health/social care professionals responded and their views are included in the report.

Requires Improvement

Is the service safe?

Our findings

Staff were trained to give people their medicines safely and there were policies and procedures in place relating to all aspects of medicine management. The manager explained that audits of medicine management were carried out and staff were re-trained if errors were found. People, or their families, were responsible for ensuring their medicines arrived on time. Staff collected emergency medicines for people if they were not able to organise this themselves. We checked the records of medicine administration (MAR charts) in one person's care records. We found that staff had not always followed the procedures correctly. For example, staff had used a code on the MAR chart to show that a medicine had not been given but there was no explanation in the care notes to explain why. Another medicine, prescribed to be given three times a day had only been given four times in 12 days. There was no explanation for this in the care notes. This meant we could not be sure that people had received their medicines safely and as they had been prescribed.

People told us they felt safe with their care workers and with the care and support they were given. They gave us several reasons why they felt safe. For example, one person said, "It's been a huge help for me, that feeling of being safe and not alone anymore." Another person told us, "Very professional staff, knowledgeable carers – that's what makes me feel I am in safe hands." The relative we spoke with also told us they were satisfied that their family member was safe. They said, "I think my [family member] is in the safest place [they] can be – without constant support [they] will not be able to live."

The provider had systems in place to ensure that people were protected from abuse and avoidable harm. One person told us, "The [staff] are all very kind. I've never witnessed anything I didn't like." Staff had received training in safeguarding people. Their responses to our questions showed that they understood their responsibilities to keep people safe from harm and that they knew how and to whom to report any concerns. Telephone numbers for the local safeguarding authority were available on notice boards.

There was a system in place to assess and reduce potential risks to each person's safety. Risk assessments in care records covered areas of potential risk to each individual such as falls, skin care, administration of medicines and infection control. Guidance for staff on the action to take to minimise the risks was clear and detailed. Assessment and management of risks relating to the environment had also been undertaken These included visual checks of equipment such as microwaves, step ladders and saucepans. Fire safety instructions advised people to remain in their flats until the fire service arrived.

The managers told us that people had to move to alternative accommodation if risk management could not keep them safe. This included people who would not be safe if they left the building unaccompanied, as the front door was always open. People were advised to keep their own front doors locked, especially at night.

We found that there were enough staff to ensure that people were kept as safe as possible and to meet people's needs. There were some mixed views about staffing levels but we found this was mainly due to some people not fully understanding the concept of extra care housing. The agency was funded to provide each person with a set number of hours of care each day, unlike a care home where staff would be available

at all times. People reported that staff usually arrived on time, did not miss calls and carried out the agreed tasks. One person said, "[Staff] are busy but this is their job and they are very professional." Another person told us, "Sometimes they are in a bit of a rush. I guess they do need to attend to others and are keen to finish the job in time." Staff told us there were "just enough" staff so that all the tasks were completed.

The provider had a thorough recruitment process in place. This included carrying out pre-employment checks such as references and a criminal records check, which had to be satisfactory before the new member of staff was allowed to start work. This helped to ensure that only staff suitable to work at this care service were employed. During and following induction staff received training to make sure they had sufficient knowledge about the safety aspects of their role to keep both themselves and the people who used the service as safe as possible.

People told us that the staff were good at following correct procedures to reduce the risk of infections being spread. One person said, "The staff are very professional. They come equipped with gloves and aprons and [they are] knowledgeable [about preventing infection]." Another person told us, "[Staff] who come to help me are always covered with protective aprons, they wear gloves and they seem very organized." Staff received training relating to the prevention and control of infection, including food hygiene, and there were sufficient supplies of personal protective equipment available. Staff told us, "We take [gloves and aprons] with us and change them for every task."

Staff fully understood their responsibility to report any incidents, accidents and concerns that they might have had. They told us about a recent incident when they had called in the area manager to support them to deal with the issue. This was discussed at a staff meeting so that staff could learn from what had happened and would feel more confident in future to prevent the situation recurring.

Good

Is the service effective?

Our findings

People's needs were assessed by their care manager (social worker) who decided whether those needs could be met at Poppyfields. They assessed the level of care the person would require from Radis Community Care (Poppyfields). Each week the manager of the service met with the housing manager and care managers to allocate any available flats. The manager visited the person and based their decision on whether the staff had the available capacity to meet the person's needs. One person said, "The social worker from the council suggested I would need more care…so two people from Poppyfields came and we had a little chat – I was very much involved. I came for a visit and I loved it."

Once each person had moved into their flat, the service's staff carried out their own assessment over a 72-hour period to determine exactly how much time the person needed staff to support them each day. This was then agreed with the commissioners.

The service used technology to enhance the care provided. People had an alarm call system in their flat so that they could call staff in an emergency. The system included wrist or pendant alarms so that people were able to use the alarm wherever they were, including if they had fallen to the floor. A relative told us that staff responded quickly when the alarm was pressed. Other alarms, such as door sensors and pressure pads, which staff responded to, were used to keep people safe. Staff carried a telephone handset so that they could ring colleagues for help if they needed to.

New staff underwent an induction process and a senior member of staff told us that all staff were undertaking the Care Certificate (a nationally recognised qualification). They confirmed that staff had received training in a range of topics such as moving and handling, safeguarding, administering medicines, food hygiene and prevention and control of infection. However, staff felt they needed additional training in subjects relevant to individual people. For example, diabetes, Parkinson's disease and end-of-life care. The manager told us that this training was becoming available via an on-line system.

People were satisfied that the staff were trained and knew how to provide the care they needed. They described staff as knowledgeable and professional.

Staff had mixed views about whether or not they felt supported. They were happy that they worked as a team and they felt supported by their colleagues and by the team leader. They felt less supported by the registered manager. Staff received one-to-one supervision from the team leader or the registered manager. Staff meetings were held regularly and staff were able to add items to the agenda if there was anything they wanted to discuss.

People and their families made all decisions about the person's meals. There was a dining room on the ground floor where a three-course lunch was provided by the housing provider. People had a choice of food and special diets were catered for. At the time of the inspection, Radis Community Care (Poppyfields) staff served lunch and supported people who needed assistance such as having their food cut up. When it was part of the person's package of care, staff assisted people with preparing breakfast and a light evening meal

and made sure people had enough drinks.

People were generally responsible for arranging their own healthcare appointments. Staff would call the person's GP if the person was not well and was not able to do so themselves. If needed, staff accompanied people to healthcare appointments. Staff liaised with other services, such as the community nurses, if people needed support with this aspect of their care. Staff had contacted an occupational therapist for advice when one person began to have difficulty with a particular piece of equipment they were using.

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. We checked whether the service was working within the principles of the MCA. Staff had received training and understood the principles of the MCA. Staff said that they always assumed a person had capacity to make their own decisions and people were always given choices. Staff asked people for their consent to the care they were giving them. The manager confirmed that at the time of the inspection everyone the service provided care to had capacity to make their own decisions. This meant that people were not unlawfully restricted and their choices and preferences were respected by the way staff worked within the principles of the MCA.

Good

Is the service caring?

Our findings

People told us they liked the staff and were very happy with the care and support they were provided with. Comments included, "The staff are very nice because they do exactly what I want them to do"; "The [staff] are really lovely and hardworking"; and, "I think that the quality of the carers here is second to none." One person's relative agreed and told us, "The care my [family member] receives is excellent." External professionals used words such as polite, helpful, professional, efficient, calm and patient to describe the staff.

We saw that staff treated people kindly and made people feel that they mattered. One person told us, "The carers I have know all about me, they all call me by my name and they even know my [relative's] name." One person told us how kind the staff had been recently when the person suffered a close family bereavement. The person said that staff had been there to support them when they needed someone, had "offered a listening ear" and had helped them to attend their relative's funeral.

Staff knew people well, including their likes and dislikes. At lunchtime staff made sure each person had the meal they had chosen and that they received their special diet if required. Staff made sure that anyone not well enough to come to the dining room had their meal delivered to them in their flat. Details about each person were recorded in their care records. For example, each person's 'morning routine' started with a section entitled 'What's important to me?' For one person this included 'I don't like to be rushed' and 'I like time to get out of bed'. It also included details of what the person preferred to have for breakfast, such as having their porridge made with water, not milk.

External professionals were impressed that staff knew people so well. One external professional wrote, "[Staff] are able to answer my questions as they are familiar with the residents' habits and associated needs. They have taken time to get to know them and build a rapport."

People, and their relatives if the person wanted them to be, were fully involved in deciding the care and support they wanted. One person told us, "The care I receive is exactly what I need, nothing more and nothing less."

The manager told us that everyone who received a service from Radis Community Care (Poppyfields) had relatives who could act on their behalf if needed. However, they said they would find out about advocacy services locally. In this way people would be aware of an independent organization that could act on their behalf should they require it.

People were satisfied that staff fully respected their privacy and dignity. Care plans included details of this to remind staff, such as 'I like privacy when using the bathroom' and 'I like to be covered during personal care'. Staff always knocked on the person's front door and called out when they entered. One member of staff said they had agreed with one person to leave the toilet door slightly ajar so that they could hear if the person needed help.

Staff knew how important it was to respect people's confidentiality. One member of staff told us that if they were held up with one person they would apologise to the next person, but not tell them why they had been held up. Care records were kept securely and confidential matters were discussed in private.

Staff encouraged people to be as independent as possible and care plans gave detailed guidance for staff on ways they could support each individual to retain their independence. One person's care plan included 'Please allow me time to complete tasks myself' and 'I can wash and shower myself'.

Good

Is the service responsive?

Our findings

Holistic assessments of people's needs were undertaken prior to a service being agreed. These formed the basis for care plans, which ensured that people received personalised care that was responsive to their individual needs. People were actively involved in planning their care and support, from the initial assessment through to care plans and care plan reviews. One person said, "My care was organised before I moved in. I know all about my care and my care is in my care plan. Social worker explained how I can change [the care] if I need to."

Care plans were personalised and gave staff good details about the care and support that each individual needed and the ways in which they wanted their care delivered. For example, in one person's care plan we read, 'I would like care staff to assist me to dress my bottom half, put a pad in place and cream my legs.' Another person's care plan stated, 'I would like you to administer my medication. This is kept in a locked cupboard in the kitchen. I would like my tablets to be put in a white egg cup'.

Care plans were updated annually or when a person's needs changed. Staff told us that any changes to a person's care were discussed by the staff team at handover. Staff also checked care plans from time to time to ensure that they were fully up to date with the care the person needed.

Staff were not responsible for organizing social activities for people as this was not part of anyone's care package. However, some activities did take place in the communal areas of the home, mainly arranged by the housing manager. Staff were given time to assist people who needed it to get to the activity from their flat. Staff also assisted to run a game of bingo once a week. When they could, staff told us they enjoyed spending time chatting to people, in their flats or in the communal areas. We saw staff encouraging people to chat to each other when they were sitting in the dining room or foyer.

The provider had a system in place so that people, their relatives and any other visitors to the service knew how to raise a complaint if they needed to. The complaints procedure was documented in the guide to the service that people received when they started to receive a service from Radis Community Care (Poppyfields). Staff were clear that they would report the matter to the team leader or manager if someone complained to them about something. We saw that a recent complaint had been fully documented and responded to in a timely manner.

At the time of the inspection no-one who was receiving a service needed end-of-life care. The service had procedures in place, including end-of-life care plans, which could be put into operation should the need arise. Staff told us that they had recently cared for someone at the end of their life. They had worked closely with the GP and community nurses so that the person was able to remain in their home to die, as they had wanted to do. Staff had not yet received training in end-of-life care.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post. She was on leave on the first day we visited the service. By our second visit she had resigned as manager and left (although had not cancelled her CQC registration). The day-to-day running of the service was being carried out by a team leader, supported by the area manager. At our second visit, a manager who was registered for two of the provider's other extra care with housing schemes was managing the service. A housing manager, employed by the owners of the building, had an office in the building. We found that during our first visit, when people spoke about 'the manager' they were talking about the housing manager and did not seem to be aware that there was a manager for the care service. An external professional told us they had been concerned for some time about the apparent lack of leadership.

Staff were clear that they were expected to uphold the values of the organisation, which included delivering high quality care and support to people who received a service. Staff felt supported by the team leader and area manager but told us they had not always felt supported by the registered manager. They said she did not always listen or respond to their concerns or suggestions. One member of staff said, "It feels like she just wants us to smooth over [the issue]."

The provider had a quality assurance system in place. This included an annual quality assurance report, completed by the provider's Quality Assurance Officer, covering a range of areas of the service. The most recent report had been completed on 3 October 2017. Radis Community Care (Poppyfields) had scored well in some areas but we saw that 'documentation' had scored poorly. Although the registered manager had completed an action plan we noted that some actions were still incomplete, even though the date for completion had passed. For example, the action plan stated that 'an audit of the MAR charts to ensure any missed medication or recording concerns can be documented and actioned' was to be 'started immediately'. We found errors in the MAR charts we looked at which had not been found or addressed.

The audit stated 'service users need to know who their carers (staff) are on a weekly basis'. This had not been implemented even though the audit had been completed more than four months before our first visit. People told us they had no idea which staff would be providing their care each day. Staff told us that they did not know to whom they would be providing care until they came on duty so they were not able to tell people.

We received some good feedback about Radis Community Care (Poppyfields), from people using the service, one person's relative and external professionals. The relative said, "They do a very good job of looking after my [family member]." External professionals told us that the service passed 'the Mum test' in that they would be happy for family members to receive the service if they needed it.

The scheme manager had started managing Radis Community Care (Poppyfields) two weeks before our second visit. They and the area manager told us they had done a lot in two weeks and were satisfied that the service was safe. They told us, "There are some fantastic staff here" and felt staff were more settled than previously. Staff told us they liked working at the service. One member of staff said, "I really enjoy working

here, it's really nice." Another member of staff told us, "I love my job here. It's a lovely place to work."

People were given opportunities to comment on the service they were receiving. A written survey was sent to people in August 2017. The scheme manager said another one would be sent out in three months so that they could judge whether the service was improving. The scheme manager was meeting face-to-face with each person so that people would get to know them and feel comfortable talking to them and raising issues if they wanted to. Following our second visit they wrote and told us they had met each person and given them their contact telephone number should they require it.

Providers of services are required by law to inform CQC of various matters, including any allegations of abuse, deaths and events that affect the running of the service. CQC records showed that we had not been sent any notifications. We checked the service's records of accidents and incidents. The records confirmed that nothing had happened which CQC should have been notified about. The scheme manager and area manager were aware of their responsibility to notify CQC.

The service worked in partnership with other professionals to ensure that joined –up care was provided to people. These professionals included GPs, community nurses, speech and language therapists and any other professionals involved in a person's care. This meant that each organisation knew what the others were doing in relation to a person's care, as far as they needed to know and the person wanted them to know.