Rehoboth24 Healthcare Solutions Ltd

# RHS24 Care Registered Office

## Inspection report

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27 November 2018

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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

This inspection took place on 22 and 27 November 2018 and was announced.

We last inspected this service in September 2017. We were unable to provide a rating for the service as the provider was not providing sufficient service to demonstrate they were able to meet the regulations. At this inspection, we found the service provided had increased and sufficient evidence was available to enable us to provide a rating.

RHS24 Care Registered Office is a domiciliary service, providing care and support to people in their own homes within Leicester and surrounding areas. Not everyone using RHS24 Care Registered Office receives regulated activity; 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. The service supports older people and younger adults. At the time of our inspection, there were seven people using the service.

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.

People's risks had been assessed most of the time. Further improvement was required to ensure potential risks people were exposed to had been identified, risk assessments were in place, reviewed regularly, and updated as needs change. Behaviour management strategies, did not always provide the detail or the measures staff needed to take to keep people safe.

Accidents and incidents were recorded. However, there was no evidence these were analysed and action taken to protect people from the risk of further harm.

Staff had completed training to enable them to safeguard people from poor care and abuse and were confident in how to report concerns.

Staff recruitment procedures ensured that appropriate pre-employment checks were carried out to ensure only suitable staff worked at the service. Staffing levels were suitable to meet people's needs, and the staffing rotas showed that staffing was consistent.

Staff supported people in a way which prevented the spread of infection. Staff used the appropriate personal protective equipment to perform their roles safely.

People's needs and choices were assessed and their care provided in line with their wishes and preferences. Staff completed training that was relevant to their role and received support from the registered manager.

This supported staff to gain the skills and knowledge they needed to meet people's needs.

People were supported to have enough to eat and drink and maintain their nutritional health if required. People were supported to access health services when required to make sure they maintained their health and well being.

Staff demonstrated they understood the principles of the Mental Capacity Act 2005 (MCA). People, and appropriate representatives were involved in making decisions about their care.

People had developed positive relationships with staff who were kind and caring. Staff treated people and their relatives with respect and protected people's right to be treated with dignity and have their privacy maintained at all times. Staff understood people's individual needs which supported people to be involved in their care.

People, their relatives and representatives were consulted and involved in all aspects of their care and were able to make changes to how their care was provided. Care plans were regularly reviewed to ensure they reflected people's current needs.

People, their relatives and representatives knew to raise concerns and complaints and were confident these would be listened to and acted upon.

Quality monitoring systems and processes were in place and audits were taking place within the service to identify where improvements could be made.

## 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 consistently safe.

Risk assessments did not always provide the detail and guidance needed, or the measures staff needed to take to keep people safe.

Staff understood their responsibilities to safeguard people. The provider's safeguarding policy required updating to ensure it was fit for purpose.

Systems were in place to record accidents and incidents, although records did not reflect analysis and review to ensure lessons were learnt and prevent further incidents.

People were supported by the right number of staff assessed to meet their needs.

### Is the service effective?

**Good**

The service was effective.

People's needs were assessed and met by staff who had the skills and knowledge they needed to provide effective care.

People were supported to maintain their health and well-being, including their nutritional needs.

Staff understood the principles of the Mental Capacity Act 2005 and sought consent before providing care and support.

### Is the service caring?

**Good**

The service was caring.

The staff were kind and caring and understood the importance of building good relationships with the people they supported.

Staff supported people to be independent and to make choices. People's privacy and dignity was respected.

### Is the service responsive?

**Good**

The service was responsive.

People were supported to be involved in the planning of their care.

Where required, people were supported to go out into the local community and staff spent time with people to reduce the risk of social isolation.

People, their relatives and representatives felt comfortable to raise concerns and knew how to make a complaint if they needed to.

## Is the service well-led?

Good

The service was well-led.

There was clear leadership and management of the service which ensured staff received the support they needed to provide good care.

People, relatives and staff were supported to share their views about the service.

The registered manager had system in place to monitor the quality of the service. On-going development of systems and processes were underway at the time of our inspection.

# RHS24 Care Registered Office

**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 checked 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 22 and 27 November 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection site visit activity started on 22 November 2018 when we visited the office location to see the manager and office staff; and to review care records and policies and procedures. The site visit activity finished on 27 November 2018 when we completed telephone calls to people using the service, their relatives and staff.

The inspection was undertaken by one inspector.

Before the inspection we reviewed the information we held about the service. This included any notifications about serious incidents or events in the service that the provider is legally required to tell us about within specific timescales.

During the inspection we spoke with two people who used the service and one relative to gain their views about the service. We also spoke with the responsible individual, the registered manager and two care staff.

We spent time looking at records, including three people's care records, three staff recruitment files, records relating to the day to day management of the service and the provider's policies and quality assurance systems.

Following our inspection, we asked the registered manager to provide us with information pertaining to polices and procedures. They did this in a timely way.

Requires Improvement

# Is the service safe?

## Our findings

People told us they felt safe using the service. Comments included, "I feel safe with staff. I get on well with them and they always check I have everything and am okay before they leave," and "I feel safe with them [staff]. They always come on time." A relative told us, "We have a consistent team of staff that know [name of family member] well. They always turn up, we have never had a missed call. They follow the care plan. We feel safe with them."

Staff demonstrated they clearly understood how to recognise possible signs of abuse and action they would take to raise an alert to make sure people were safe. This included reporting to the registered manager, or external agencies if they had concerns about poor lpractice within the service, referred to as whistleblowing.

The provider had safeguarding and whistleblowing policies in place for adults. We found these required further development to ensure they were fit for purpose, and provide staff with the up to date information and guidance they needed to follow safeguarding protocols and raise whistleblowing concerns. For example, the whistleblowing policy did not provide contacts for external agencies for staff to contact outside of the service. The provider has several policies on adult abuse and safeguarding; these referred to out of date guidance and contact details. Following our inspection, the provider sent us the revised policies which reflected current guidance and best practice for adults, including contact details of relevant external agencies which they would share with staff.

People were protected from the risks associated with their care because the provider followed appropriate guidance and procedures. Each person's care plan had an assessment of the risks the person may be exposed to. Risk assessments included areas relating to the environment, for example access and potential hazards around people's homes and risks to the individual. For instance, risks associated with people's health conditions, lifestyle choices and the use of equipment, such as walking aids. People's care plans identified what action staff needed to take to reduce the risk whilst meeting people's needs and promoting their independence. For example, where one person was at risk due to poor food hygiene, measures were in place that enabled staff to take action, whilst acknowledging the person's right to make unwise decisions.

Not all risk assessments were in place or updated when people's needs changed. We found risks assessments were not in place for one person who was known to be at risk of substance abuse. For a second person, their risk assessment had not been updated to reflect recent changes in their circumstances. The registered manager demonstrated they were knowledgeable about the actions required to reduce known risks. They told us they would ensure records were developed and updated so staff had the information and guidance they needed to manage risks.

Staff did not always have all the information they required to manage the risks of people who that had behaviours that challenged others. Care plans identified where people could experience times of agitation and distress, and described the form of behaviour a person could demonstrate. However, there were no strategies in place to enable staff to provide consistent and effective intervention in response to behaviours that challenge. The registered manager told us they had attempted to liaise with mental health

professionals to develop joint-working and effective strategies. They told us they would ensure appropriate strategies and guidance was in place following our inspection.

The provider had systems in place to enable staff to record and report incidents and accidents in the service. We saw incidents had been recorded. However records did not show incidents had been reviewed and measures implemented to reduce the risk of further incidents. The registered manager demonstrated they had followed up incidents but this information was not reflected in recordings. They told us they would ensure records clearly reflected incident reviews and actions taken to demonstrate how these were used to learn lessons and prevent further incidents occurring.

People were either supported by their relatives to take their medicines or were able to manage these independently with staff verbal prompts. Some staff had completed training in administering medicines and the registered manager told us this was planned for all staff in the event people required support with their medicines. The registered manager had measures in place which supported people with ordering and collecting their medicines. This helped to ensure people took their medicines as prescribed.

There were enough staff available to meet people's needs as assessed in their care plan. People and relatives told us staff always arrived on time, never missed a call and stayed for the full duration of the call, sometimes longer. People received care from a consistent team of staff and told us this gave them confidence and helped them to feel safe. The provider had a monitoring system in place where staff had to call in before and after a call to register their attendance. This helped the registered manager to ensure people received their calls as agreed.

The registered manager followed safe recruitment and selection processes. We looked at the recruitment records of three staff. We saw background checks were carried out to make sure applicants were suitable to provide care to people who used the service. This included a check with the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people using care and support services.

The provider had policies and procedures in place to support staff to protect people from the risk of infections. Staff described how they followed infection control procedures, which included washing hands and wearing protective clothing such as gloves and aprons.  People's care plans emphasised the need to reduce the risk of people acquiring an infection. For example, one person's care plan described protective clothing staff should wear to support the person with their continence care.

Good

# Is the service effective?

## Our findings

People and relatives told us they were confident that staff had the skills and knowledge they needed to meet their needs. One person told us, "They [staff] are good. They provide care how I want them to." A relative described how staff how responded to changes in their family member's health condition which meant their needs were met.

People's needs were assessed during an initial assessment prior to them using the service. The assessment covered people's physical, emotional and social care preferences to enable the service to meet their diverse needs. The registered manager liaised with people. their relatives and health and social care professionals involved in people's care to gather information which formed the basis of the care plan. This process helped to assure people their care would be delivered in line with up to date legislation, standards and best practice.

Staff told us they felt they had access to training that gave them the skills and knowledge to meet people's needs. One staff member told us, "My induction was good. It covered manual handling including hoisting, medicines, health and safety and expectations of me and standards of recording information. I worked with [senior manager] who showed me what to do, explained everything and introduced me to people." A second staff member told us, "Much of the training is on-line and we can work through this. I have a lot of prior training and have completed my NVQ2 (vocational qualification in care). We have enough training and managers monitor and call us in when we need to update training." The provider maintained a central record of training for staff, referred to as a training matrix. This showed staff had completed training the provider believed was essential, for instance safeguarding and infection control, and training specific to people's needs, for example end of life. New staff were supported to work through a set of induction standards and managers undertook competency checks and observations to ensure staff were providing care as planned.

Staff told us they felt supported in their roles, though they did not always receive formal supervision. Staff comments included, "I don't have supervision but I can always call them [managers] if I need advice or guidance. They do sometimes come to check on me when I am with a customer, to make sure I am doing everything right," and "I am well supported in my job. Sometimes managers tell me I am doing a great job." Records showed supervision was not carried out consistently for all staff. Supervision is important as it provides an opportunity for staff to meet with their managers and get feedback on their work and identify areas where they may need support or development. The registered manager told us senior managers met with staff each week through spot checks of working practices and used these as opportunities to discuss issues with staff. However, these sessions were not consistently recorded. They told us these sessions would be recorded and they would ensure staff had access to regular, formal supervision to support their development.

Staff supported some people with their meals and encouraged people to maintain a healthy, balanced diet. People had care plans in place setting out their likes and dislikes and whether any cultural or other factors affected what they ate. For example, where one person was assessed as at risk from poor nutrition, their

care plan included staff support to purchase foodstuffs, undertake food safety checks to ensure food was safe to consume and take the person out for hot meals. One person told us staff made their breakfast and always ensured they had sufficient drinks between visits.

People were supported to maintain good health. People's care plans included guidance about people's health needs, including the impact health conditions had on people's well being. This information helped staff to provide effective care. For example, one person's care plan described them as experiencing breathlessness as part of their health condition. The care plan guided staff on how best to support the person during these times. Records showed staff were attentive to relatives where they were primary carer for a person and supported them to access appropriate healthcare if they were unwell. Staff recognised the impact that a relatives poor health could have on the care provided. This was confirmed by the relative we spoke with who appreciated the support of staff which in turn enabled them to care for their family member.

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 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. In community care settings, this is under the Court of Protection.

We checked whether the service was working within the principles of the MCA. Staff had received training in the MCA and they were able to demonstrate an understanding of the key principles of the act and described how these informed their practice. They told us how they supported people to make their own choices and asked for people's consent before providing their support. This included acknowledging people's right to make unwise decisions and choices if they had mental capacity to do so. Mental capacity assessments had been completed for people using the service and these were regularly reviewed.

Good

# Is the service caring?

## Our findings

People and a relative we spoke with told us staff were kind, caring and respectful. Comments included, "I get on well with the staff, we have a chat. They always check if there is anything I need before they leave," "We have good care from staff who know [family member well. They are respectful of our home and always ask how we are," and "The staff are good and I am happy with them."

People and a relative explained they were involved in setting up their package of care to ensure it met their requirements. Their wishes and views were listened to during this process and their care plan developed using this information. For example, one person had stated it was important to have chatty, sociable care staff supporting them as they liked to talk with people. Care plans also guided staff on how best to communicate with people. For instance, one person required staff to talk directly in front of them to support their hearing impairment. This information demonstrated people were involved and supported to make decisions about their care.

Staff told us they had sufficient time to provide the care people needed. People and a relative told us staff gave them the time they needed, never rushed them and always checked if they needed anything before they left. The provider allowed for travelling time between calls to reduce the risk of staff being delayed.

People and a relative told us staff were respectful and courteous to them. One relative described how staff were respectful of their role as their family member's main carer. They told staff always made sure they were well and had everything they needed during the care call, as well as providing the care their family member needed. This made them feel valued and involved in their family member's care.

Staff understood the importance of promoting equality and diversity, respecting people's religious and cultural beliefs, their personal preferences and choices. People were able to choose whether they wanted male or female staff to provide their personal care.

People were supported to develop and maintain their independence. Care plans detailed people's abilities and described the level of support they required from staff. For example, records described what people could do for themselves as part of their personal care and when staff should step in to assist.

Staff described how they protected people's right to dignity and privacy and this was confirmed by people we spoke with. For example, ensuring curtains were closed and people were covered during personal care. Staff had completed training in dignity as part of their induction.

Staff had signed confidentiality agreements as part of their induction training and demonstrated they protected people's right to have their information protected. People's care plans were stored in an agreed place in their home and staff returned care plans once they had completed the record of their visit. Copies of care plans and records were stored securely at the office, accessible only by relevant personnel. The provider had reviewed the requirement of the General Data Protection Regulation (GDPR) to ensure people's data was stored and managed in line with legal requirements.

Good

# Is the service responsive?

## Our findings

People and a relative felt the service was responsive to their needs and that care was provided in line with their wishes and preferences. One person told us, "I can ring them up if I need to make any changes. I have had a meeting about my care recently." A relative told us, "[Name of family member] needs have changed a lot and staff have responded to this. They spend time with [Name] talking. The office rings me up every week to check everything is okay. They are always at the end of the phone if I need them."

People had care plans in place that were developed in consultation with people and their relatives. People's decisions and choices, or those of their representatives, were used to form the basis of an agreement between the provider and the person and informed the care plan. Care plans included details of people's life histories, people who were important to them and preferences and wishes. Routines that staff should follow were detailed for each visit. For example, how they should greet the person, in what order people liked their support to be provided and things people liked to have around them. This information supported staff to provide personalised care.

The registered manager was in regular contact with people and their relatives to ensure the care provided met their current needs. People and a relative told us the registered manager visited them at home or contacted them by telephone to check they were happy with the everything or if they needed changes to their care. Records showed people and relatives were involved in reviews of their care and outcomes of reviews were recorded, together with any changes to the care plan.

Staff were aware of people who were at risk of social isolation. They spent time talking with people and engaging with them in areas of interest. Staff told us they were aware that, for some people, staff were the only people the person had contact with through the day and therefore made the most of the time they had together. Where required, staff supported people to access the local community for shopping, meals out and community centres.

At the time of our inspection, the provider did not have a policy detailing how they complied with the Accessible Information Standard (AIS). People using the service did not require information in a specific format. The AIS is a framework put in place from August 2016 making it a legal requirement for providers to ensure people with a disability or sensory loss can access and understand information they are given. The registered manager told us they would implement a policy following our inspection.

People and relatives knew how to report concerns. They were clear on who to contact but told us they had had no reason to complain about the service to date. The provider had policies and procedures in place to support people to make a complaint, though no complaints had been received at the time of our inspection. We found these required further development to ensure details were up to date and clarify the process of making a complaint. Following our inspection, the registered manager provided us with a revised policy and procedure and we found these were fit for purpose.

At the time of the inspection, no people using the service were receiving end of life care. The service

understood the importance of providing good end of life care to people and the registered manager confirmed that support would be given to those who wished to make advance decisions about the end of their life.

Good

# Is the service well-led?

## Our findings

People and a relative were positive about the management and leadership of the service. Comments included, "I think it is well managed. I am happy enough with it," "Staff provide good care. I am very happy and have no concerns," and "I am happy. they [staff] are good."

There was a registered manager who was new to the post at the time of our inspection. They had spent time introducing themselves to staff, people and relatives. They were supported in the day to day running of the service by a care co-ordinator who planned visits and senior care staff who undertook spot checks and supported staff. Staff felt the service was well managed overall. Comments included, "There is good communication. The manager will always call and ask if I need anything and if I have any questions, I just call them and they give me advice. They keep me informed of developments in the service," and "I think the service is well managed because they follow procedures and support staff to ask questions."

The quality of care was regularly monitored. The registered manager told us they undertook announced and unannounced spot checks on staff competencies and this was confirmed by people and staff. Checks included presentation and timekeeping of staff, quality of care provided, communication and documentation. The registered manager did not maintain consistent records of checks. They told us they would develop formal quality assurance records to demonstrate the outcome of their audits and checks following our inspection.

Staff were supported to be involved and contribute to the running and development of the service through staff meetings. These included conversations about best practice and informed staff about proposed developments within the service, for example, new business. Staff had completed satisfaction surveys, providing feedback on their experience of the service. We looked at surveys that had been completed in August 2018 and saw these were largely positive, although some staff had expressed dis-satisfaction with work patterns and training. The registered manager explained there had been a turnover of staff as they had been unable to provide some staff with the hours they required due to limited care packages.

People and relatives were supported to share their views through regular satisfaction surveys, reviews of care and informally. Surveys returned in September 2018 were positive about the care provided. However, where people had made comments, there was no evidence these had been followed up. For example, one person had stated they were not aware of the complaints procedure. Records did not demonstrate action had been taken to ensure the person had the information they needed to make a complaint. The registered manager told us they would collate information from surveys and ensure action taken was evident in records.

The service had a clear vision and strategy to provide positive care for people. These centred around the five C's of caring, Commitment, Conscience, Competence, Compassion and Confidence. The registered manager and staff described how the service aimed to work with people, to support them to be as independent as possible and live life as they wanted to. The registered manager and staff we spoke with, all had a good knowledge of the people that were using the service, and how to meet their needs. The staff team was

diverse and came from a range of cultures and backgrounds. Staff spoke about feeling valued, being treated equally and having their diversity recognised and supported.

Staff worked in partnership with external agencies, such as occupational health therapists and community mental health workers. The registered manager was in the process of developing links with other agencies which would help to promote agencies working together to ensure people were provided with the care they needed.

The registered manager and the provider demonstrated they were aware of their legal responsibilities to notify us of significant events and incidents within the service. Systems and processes were in place to support this.