RA Care Services Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out this announced comprehensive inspection on 20 September 2018.

RA Care Services Ltd is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. At the time of our inspection the service was providing care to four people. At our last comprehensive inspection in March 2017 we rated this service 'requires improvement'. We changed this rating to 'good' following a focussed inspection in December 2017. At this inspection we found the service remains 'good.'

The service had a registered manager, who was the managing director of the company. 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 provider had recently appointed a new manager who intended to take over as the registered manager.

Care workers received suitable training when they joined the service as part of a recognised induction programme, but it wasn't clear how often training needed to be repeated. We found that supervision and checks of staff capacity had been taking place consistently in the past few months.

There were detailed assessments carried out of people's care needs and daily living skills, including those relating to the support people required to maintain their personal care, eating and drinking. These were used to devise care plans which met people's needs, but there was considerable repetition in these plans. At times consent to care was obtained from people's relatives rather than the person, and assessments of capacity were not decision specific. We have made a recommendation about how the provider obtains consent to care.

The provider operated systems for assessing risk and had plans in place for ensuring people received safe support. People's living environments were assessed for safety and measures were in place to prevent the spread of infection. People told us their care workers arrived on time and stayed for the required duration. People were not receiving support with their medicines at this time.

There were measures in place to ensure care workers were suitable to carry out their roles, but we saw one instance where the correct previous job reference had not been obtained for a care worker. We have made a recommendation that the provider amend their recruitment processes to prevent this occurring in future.

The service gathered detailed information on how people's cultural and religious needs were met, and their preferences for their care. Reviews and quality assurance checks were used to obtain peoples' views about their care. Managers had audit systems in place for monitoring the quality of the service and documentation.

People using the service were not English speakers and told us they benefitted from receiving care from staff who could speak their language. People told us that care workers understood their needs and treated them with respect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe using the service and there were suitable measures to safeguard people from abuse.

The provider assessed risks to people and had management plans to mitigate these. There were measures in place to monitor accidents and incidents.

Care workers were recruited in line with safer recruitment processes. Care workers arrived on time and stayed for the allotted time.

Is the service effective?

Requires Improvement

The service was not always effective.

Care workers received training as part of a detailed induction, but there was a lack of clear guidance on how often training should be repeated. Care workers received supervision and regular checks of their practice.

Assessments of capacity lacked detail on how people could make specific decisions and sometimes consent to care was acquired from a relative rather than the person.

The provider carried out detailed assessments of people's care needs and those relating to nutrition. People's health conditions were assessed and how these impacted on their living skills.

Is the service caring?

Good

The service was caring.

People's views were obtained about their preferences for their care and how their cultural and religious needs should be met.

People were supported by people who spoke their language and understood their culture. Care plans were clear about how people could be supported to communicate. There were systems in place for obtaining people's views about their care.

People told us they were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People had plans in place for their care which were reviewed regularly to check they still met people's needs. Records showed that people received the right care, but records did not routinely record how people's moods and wellbeing changed.

The provider had assessed people's language and communication needs but plans were not always presented in a way which people could understand.

People could make complaints and there were procedures in place for addressing these.

Is the service well-led?

Good

The service was well led.

There were systems of audit in place to check that records of care were complete and accurate.

Managers used quality assurance visits and feedback forms to obtain peoples' views about their service and staff views about the support they received.

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Detailed findings

Background to this inspection

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

This was a routine inspection. We were not aware of any serious incidents or issues of concern regarding this service.

Prior to carrying out this inspection we reviewed information we held about the service and another service run by the same director. We checked the company was in good standing at Companies House and that the provider was displaying their ratings on their website. We asked the provider to complete a Provider Information Return (PIR). This is a document which asks the provider to give information about how they think the service is performing and their plans for improving the service in future.

This inspection was carried out by a single adult social care inspector. The day before the inspection we worked with a Bengali speaking interpreter in order to make calls to people who used the service and care workers. We spoke with two people who used the service and one care worker.

The inspection site visit took place on 20 September 2018. We spoke with the company director, the care manager and a member of office staff. We reviewed records of care and support for four people who used the service. We checked records of recruitment, training and supervision for four care workers.

Good

Is the service safe?

Our findings

People told us they received a safe service and could speak to the manager if they didn't feel safe. Care workers received suitable training in safeguarding adults and the provider had a policy in place which identified forms of abuse and the roles and responsibility of care workers in preventing abuse. A care worker we spoke with said they were comfortable raising issues of concern with the manager and these would be acted on. Competency checks and supervisions were used to check a care worker's understanding of their responsibility under the safeguarding processes.

The provider had a system of assessments in place for managing risk. There was a mobility risk assessment which assessed how people made transfers and any equipment that was in place to support this. Nobody was supported to use a hoist, but the provider's assessment required the assessor to check if a hoist was in place, was safe to use and had been serviced. Assessors also checked non lifting equipment such as crutches and toilet frames. The provider assessed the safety of the person's home and any environmental factors which may impact on the person's wellbeing. Risk assessments for personal care highlighted factors which may cause injury such as hot water or wet floors and infection control measures such as using different flannels for different parts of the body. Nutritional support plans also included instructions for care workers on cross infection risks and how these could be managed, such as the use of aprons, handwashing and safe storage of food.

Risk assessments covered the use of substances that could be harmful to a person's health such as cleaning materials and deodorants and contained advice on what to do in the event of an accident involving these substances.

The provider considered how people would call for help in an emergency, including if they were unable to contact emergency services due to language issues. Risk management plans, including how to call for help were discussed and reviewed in regular care plan reviews.

People told us their care workers arrived promptly and stayed for the required period of time. Timesheets and records of care received showed that staffing levels matched people's assessed needs.

The provider operated safer recruitment procedures to ensure that care workers were suitable for their roles. This included obtaining a complete work history, proof of identification and address and carrying out a check with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions. The provider had obtained two references from previous employers, and had telephoned the referee to verify the reference. However, for one care worker they had obtained two references but could not produce a reference from the most recent employer where they had worked as a care worker, which meant there was not evidence of satisfactory conduct in previous health and social care. The provider told us that they had obtained this reference but had mislaid this when archiving old files. Processes were in place to check two references were seen and verified but not necessarily that they evidenced satisfactory conduct in previous health and social care when required.

We recommend the provider take advice from a reputable source on ensuring recruitment processes are reviewed in line with schedule three of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us they were not supporting people to take their medicines or administering these. We confirmed this by checking care plans and daily logs. The registered manager told is they planned to introduce support with medicines only when they had sufficient office staff to monitor this. They said, "It requires monitoring more often."

The provider had a process for recording when incidents and accidents had occurred. This included recording what immediate action was taken and whether subsequent actions were required. The process included actions such as updating a person's risk assessment or care plan and whether additional monitoring was required. The provider's accident and incident policy contained guidance for care workers on immediate actions to be taken and how incidents were reviewed. The provider told us there had not been any recent incidents or accidents, so we were unable to see how this process was followed. Staff had received training in first aid in line with this policy.

Requires Improvement

Is the service effective?

Our findings

The provider had processes in place to assess people's needs. The assessment was used to assess people's needs in a wide range of areas. These included the care tasks people could do for themselves and needs relating to personal safety, mobility, social support, dietary requirements and religious needs. The provider assessed how people carried out day to day living skills and whether there were issues such as physical dexterity which may impact on these. The provider assessed the informal and family support the person received and whether the family carer had any health issues or commitments which could impact on their caring role. This assessment was used to inform a detailed care plan.

Staff received adequate training to carry out their roles, but there was a lack of clear guidance on how often mandatory training needed to be refreshed. A member of office staff said "They've been very patient with me and I'm getting to know the office. New staff undertook an induction programme in line with the provider's induction policy which included the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It's made up of the 15 minimum standards that should be covered if a staff member is 'new to care' and should form part of a robust induction programme. Care workers had received training in key areas such as safeguarding adults, fire awareness, health and safety, mental capacity and risk assessment. Additional training had included dementia and depression and moving and positioning.

Three of four care workers had been with the provider for under a year and had received training as part of their induction. One care worker had been with the provider for longer and had received their training in February 2017. The care worker's file showed proposed dates for repeating this training in the coming months, but the provider's policy did not have a clear framework for how often training should be repeated. After the inspection the provider showed us evidence that this was now in place.

Care workers had received formal supervision in the last three months. The provider followed a framework for supervisions which included choosing two key points to be discussed from a list which included medicines, confidentiality, the provider's no response policy and safeguarding adults. Before the most recent supervisions some care workers had not received supervision for up to seven months since joining the organisation. There were systems in place for carrying out spot checks on care workers and assessing their competency. These had not taken place for up to seven months when people had joined the organisation but were now taking place monthly. The provider told us that care workers did not receive supervision when they did not have care packages allocated to them. The provider used these spot checks to assess care worker's knowledge and skills and ensure that their approach was suitable and respectful.

The provider had assessed people's health needs. Plans included information on health conditions and past injuries or life events which affect people's daily living. There was information on how these conditions impacted on people's lives, this included when people were in pain, unable to bend or reach items or were not able to access the community with support.

There was sufficient information on people's nutritional needs and support. The provider carried out

nutritional risk assessments which included information on allergies, peoples' dietary preferences and cultural needs and the level of support required to prepare meals, serve food and to eat. Care workers had recorded that they had supported people in line with these plans and showed the dietary choices people had made.

The service was not always working in line with the Mental Capacity Act (2005) (MCA). The Act 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. Two people using the service had capacity to make decisions about their care and had signed to record consent to their care. Assessments included checking whether a person had a history of dementia or mental illness which could affect their capacity to make their own decisions, but these lacked detail on other factors which could affect capacity and did not reflect that capacity is decision specific.

The service was supporting two younger people with learning disabilities. The provider told us that they thought these people had the ability to consent to their care but lacked capacity to make other decisions, but had not carried out an assessment of capacity. In both cases it was recorded that the people using the service were unable to sign without an explanation of why. A family member had signed on their behalf, even though they did not have the legal authority to do so. The provider had discussed with people and their relatives whether obtaining legal authorities such as powers of attorney were appropriate.

We recommend the provider take advice from a reputable source on ensuring consent is obtained in line with the MCA. The provider told us after the inspection that they had requested mental capacity assessments be carried out where necessary.

Good

Is the service caring?

Our findings

People told us they were treated with respect and were given privacy by their care workers. People we spoke with were happy with their care workers and the support they received. The provider had a dignity charter included in the information they provided people, which outlined how they would respect their rights and promote confidentiality. Person-centred care training formed part of care workers' inductions which included the importance of treating people with respect.

People had one page profiles in place, which included information on what care workers needed to know about a person, what was important and how to support them. This included people's religious needs and cultural backgrounds, information on culturally appropriate foods and preferred choices for breakfast and hot drinks. Plans included information on people's work histories, family situations and details about who their main carers were.

People's care plans included information on other important aspects of people's cultural needs, such as whether they required support from staff to perform salah or required halal food, or which radio stations a person listened to for Qur'anic recitation. There was also information on whether people preferred to be supported by male or female care workers, and logs of care showed that these were met.

People who used the service were Bengali speakers and in most cases did not speak any English. Care workers were also Bengali speakers and spoke the same Sylheti dialect as the people they were supporting. The registered manager told us "What we do is we send the care workers who have a similar cultural background and can speak the language. I can speak Bengali as well."

The provider obtained people's views through regular telephone monitoring and reviews. At times telephone monitoring forms showed that people were happy with their care but lacked specific detail about the conversation which had taken place. However, review forms showed when people had identified specific care workers they were happy with.

People's independence was promoted. The provider had assessed people's daily living skills and in doing so had identified what people could do for themselves. This information was included in people's care plans. Care workers recorded what people had done for themselves during each visit.

Good

Is the service responsive?

Our findings

People's plans of care were outcome focussed, and included objectives for their care as identified by the provider's assessment. Care plans were clear about the exact tasks that care workers needed to carry out on each visit, such as assisting people with transfers, laundry tasks, cooking and personal care.

There was information on how to respond to changes in people's moods but levels of detail were variable. One person's plan stated they needed space when upset but supervised to ensure their well-being, and another person's plan showed how their behaviour could vary and the importance of giving them space. There was no information on the person's daily logs to indicate how their behaviour had varied. One person's plan highlighted how changes in the person's routine could lead to frustration but there was no information on what sort of changes could lead to this, but managers we spoke with demonstrated a detailed understanding of these. A care worker told us that the person they were supporting was often tearful, but this was not reflected in their daily notes which simply detailed the support they had received.

Care workers completed logs of each visit which showed that people received care in line with their plans. This included documenting whether people had chosen a shower of bath, when people received planned support with meals and evidence of community engagement. Each person's daily logs were personalised with tick boxes in place for key tasks as identified on the care plan and a space for free text for care workers.

Three out of four people had been using the service for less than a year, but had had reviews of their care plans in the last six months. Reviews were used to assess if there were any changes required in the care plan and whether people were happy with their care workers. The provider discussed with family members any issues of concern regarding the person's home and had considered whether further discussions were required with the local authority about changing care packages, and whether family members should consider obtaining powers of authority.

The provider was only partially meeting the accessible information standard (AIS). Assessments included information on people's sensory needs and the aids people used such as glasses or hearing aids. One person told us care workers were aware of their needs relating to sensory impairment.

Plans highlighted people's language needs and included when people were Bengali speakers, including the dialect of Bengali they spoke and whether they would require an interpreter to speak with an English speaker. The provider was aware that some people using the service were unable to read or write Bengali or English, and said if appropriate they would supply plans in Bengali. However, plans lacked detail on how people were supported to understand their contents and whether other formats such as pictorial formats may be more appropriate. The care manager recognised the need to update some documents and told us "I have been looking at the core needs assessment. There's no pictures and it looks like a boring document. Some of the questions are quite repetitive so I want to streamline it."

The provider had a complaints policy and a procedure in place to ensure that complaints were investigated and that there was learning from complaints. There had not been any recent complaints. People we spoke

with told us they could contact the manager if they had any concerns but had not had cause to complain.

Good

Is the service well-led?

Our findings

People told us that the registered manager visited them to make sure that they were happy with their care. Spot checks were used to check people and their families' awareness of how to safeguard people from abuse and how to respond to accidents and to make complaints. Managers carried out monthly quality assurance checks with people who used the service to check that care workers were following their care plans, arriving on time and whether people were satisfied with the service they received.

Care notes were audited by managers to ensure that they were correctly completed by care workers and whether additional charts were required. Managers also audited people's files to ensure that mandatory assessments and risk assessments were in place, and that care plans had been reviewed at least annually. Care and support plan audits were carried out yearly across the whole service, and checked whether plans had any agreed outcomes recorded and that life story work and risk assessments had been completed. There was also a yearly audit of all care worker's files.

Assessments and care plans contained important information about people's care and health needs, but we saw that this information was very often repeated over several pages which meant that plans were more complex than they needed to be. The care manager told us that they were aware that plans were quite repetitive and they intended to streamline these. Assessments contained some minor errors about family roles, such as stating a person's mother prepared their meals which were not detected by audit. The provider told us that they had picked up in audits that daily logs were lacking in detail and were planning to address this with care workers.

Managers maintained records of contact with people using the service and their families, including when people had expressed views about the service and any agreed actions, such as providing new gloves. The provider used quality assurance visits to obtain people's views about the quality of the service, such as whether care workers followed the care plan, were punctual and whether they would recommend the service to a friend or family member. The provider also carried out surveys with key workers about their performance, such as whether the provider arranged sufficient training, what people liked about their jobs and anything they would do differently.

Each care file had a checklist in place. These checked that documentation was up to date in key areas such as consent, assessment, plans, reviews, several different categories of risk assessments and ensured that a signed contract was in place.

There were regular meetings of the management team on how to maintain the quality of the service. This included implementing monitoring forms for log sheets, carrying out checks of staff files and obtaining feedback to monitor the quality of the service.

At the time of our inspection the provider had appointed a new care manager and the director was planning to disengage from the day to day running of the service. The provider was displaying their ratings on their website and in their registered location.