RV Extra Care Limited

# RV Care Limited - Sussex

## Inspection report

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## Ratings

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

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

# Summary of findings

## Overall summary

RV Extra Care - Sussex is a domiciliary care agency registered to provide personal care to people living in their own houses and flats, most of whom live within the grounds of a retirement village. It is registered to provide care to those living with dementia, older people, physical disabilities, sensory impairments and younger adults.

This comprehensive inspection took place on 18 July 2018 and was announced. This was the first inspection of this service since it was registered on 25 August 2017.

Not everyone using this service receives a regulated activity. The Care Quality Commission (CQC) only inspects the service being received by people provided with personal care, which means help with tasks related to personal hygiene and eating. Where people receive personal care we also consider any wider social care provided. At the time of our inspection the service supported five people with their personal care needs.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had recruited to the role of registered manager and the person was in the process of obtaining CQC registration. A registered manager from another branch was providing cover as acting manager.

Quality systems and audits were in place to monitor the service people received, but did not always effectively identify areas for improvement. We found that some quality assurance processes were not undertaken as scheduled. The provider recognised these areas needed to be addressed and the acting manager had a support plan in place and we saw evidence this was being actioned. While these improvements were being made, time was now needed to fully embed the new systems and processes to sustain improvement. We did not find these inconsistencies had impacted on the safety of people, but is an area of practice that needs to improve.

People were protected from avoidable harm. There was a safeguarding policy and staff received training. Staff knew how to recognise the potential signs of abuse and knew what action to take to keep people safe.

Good systems and processes to keep people safe were maintained. One person told us, "They make me feel safe, they know what they're doing." Risks to people had been identified and staff understood people well and how to manage risks to help ensure people were safe. People were supported to receive their medicines safely by staff that were trained in administering medicines. The provider had a lone worker policy to ensure staff were kept safe in the community.

Staff were employed using appropriate recruitment practices. Staff received an induction and received

essential training. When the acting manager identified additional training needs, we saw that this was put in place. Staff told us they felt well supported by the acting manager and the wider management team. One member of staff told us, "Its lovely to work here, I've been very happy here." There were enough staff to cover all care visits and people said that they had enough time with care staff and their calls were never missed.

People were supported to maintain their health and had assistance to access health care services when they needed to. Staff supported people by arranging healthcare appointments for them. A community health professional told us that when carers had concerns about people's health they were contacted appropriately. Staff understood the principles of the Mental Capacity Act [2005] and where people lacked capacity we saw appropriate assessments were made and were decision specific.

People told us the staff were kind and caring and they were happy with the service they received. People were involved in developing their care plans. One member of staff told us, "We look after residents well, I think people will say they get good care." Staff supported people to have choices over food and drink and supported them to remain as independent as possible in their home.

People were confident their concerns would be responded to and knew how to raise any concerns and make complaints if needed. People were supported to pursue activities and interests that were important to them. People told us the service was improving under new management. Staff told us they felt supported by the management team and there were clear lines of responsibility and accountability. Staff achievement was recognised and encouraged. One person told us, "We have nothing negative to say, it's all been positive. Since living here I'm happy with the care and support, everyone is kind and caring in my eyes."

Further information is in the detailed findings below.

## 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.

The provider had policies and procedures on safeguarding people from possible abuse and neglect. Staff knew how to recognise the signs and they knew what to do if they suspected any abuse had occurred.

Risks to people were assessed and recorded so staff knew how to keep people safe.

Sufficient numbers of staff were provided to meet people's needs.

People received their medicines safely.

### Is the service effective?

Good

The service was effective.

Staff received an induction when they started work and were trained in relevant areas.

Consent to care and treatment was sought by staff on a daily basis, and staff understood their responsibilities with regard to the Mental Capacity Act 2005.

People were supported to eat and drink enough and could exercise choice.

People were supported access other health care services.

### Is the service caring?

Good

The service was caring.

People were supported by staff that knew them well and understood what was important to them.

People were included in making decisions about their care, and they received their care at times that were convenient for them.

Staff supported people to maintain their independence and promoted people's privacy and dignity.

## Is the service responsive?

**Good**

The service was responsive.

Care plans and risk assessments provided guidance on how people needs were to be met, and reflected their preferences and choices.

Staff stayed for the allocated time of the visit and people said they never felt rushed.

People knew how to complain and felt comfortable to do so and said their concerns were addressed.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well-led.

Systems and processes for monitoring the quality of the service were not always effective in identifying shortfalls and inconsistencies. This was recognised by the provider who had taken steps to address these issues.

There was new management in place that provided clear leadership and staff knew what was expected of them.

There was good communication where staff felt comfortable to raise any issues or suggestions.

# RV Care Limited - Sussex

**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 comprehensive inspection took place on 18 July 2018. We gave the provider 48 hours' notice of the inspection visit, because the location provides a domiciliary care service and we needed to be sure the manager, staff and people we needed to speak to were available. The inspection team consisted of two inspectors.

Before the inspection we reviewed information we held about the service including any notifications (a notification is information about important events which the service is required to send to us by law) and any complaints that we had received. The provider did not meet the minimum requirement of completing the Provider Information Return at least once annually. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we made the judgements in this report.

During the inspection we spoke to three people who used the service and one relative. We interviewed two members of care staff, one during the inspection and the other after the inspection by telephone. We spoke with the acting manager and the care co-ordinator and community health professionals who had contact with the service. We looked at a range of documents including policies and procedures such as safeguarding, incident and accident records, medication protocols and quality assurance information. We looked at care plans for three people who used the service. We reviewed three staff files including information about recruitment, supervision and training. We reviewed team meeting minutes and feedback from people who use the service.

This was the first inspection of this service since it was registered on 25 August 2017.

Good

# Is the service safe?

## Our findings

People were protected from the potential risk of abuse because staff had received training and understood how to identify and raise safeguarding concerns according to the provider's reporting procedure. There had been no safeguarding notifications reported to us since the service registered with the CQC. The provider had policies and procedures in place to manage safeguarding concerns. Staff described the steps they would take to record a safeguarding concern to the office and the acting manager described the steps they would take to report to the local authority and the CQC when required. Staff explained types of abuse that people may experience such as financial, physical, emotional and self-neglect. We saw in one person's care plan that staff had sought the advice of the local authority safeguarding team when they had concerns about a person's wellbeing.

People told us they felt the service was safe. One person told us, "They make me feel safe, they know what they're doing."

Care plans showed that risks to people were identified so staff could provide care in a safe environment. Environmental risk assessments such as identifying hazards in the home were carried out before delivery of care. There was an assessment of people's general health, wellbeing and communications needs. Care plans considered other risks to people such as mobility, risk of falls and their nutritional needs. In one care plan we saw that the person had a poor appetite which was identified as a risk. Staff described how they supported the person to prepare a hot meal and ensured the person was safe afterwards by arranging a welfare check from the front of house staff after lunchtime.

There was a lone working policy to keep staff safe in the community. There were up to date health and safety risk assessments including fire risk assessments.

Staff recruitment processes showed that suitable staff were selected to work with people. Staff files showed prospective staff had completed an application form and been interviewed. Their file included previous work history and the provider had obtained written references from previous employers to assure themselves of a candidate's suitability. Photographic identity was also on file. Checks had been made with the Disclosure and Barring Service (DBS) before employing any new member of staff. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. Staff had received an induction on commencing employment which included infection control, first aid, health and safety, Mental Capacity Act [2005] and dementia awareness as well as the provider's policies and procedures.

There were sufficient staff to meet the needs of the small number of people that currently used the service. Staffing levels were planned around the needs of people and people told us they had sufficient time on their allocated visits. Staff absence, such as annual leave or sickness, was covered by regular staff. Staff told us that during a period of bad weather with snow and ice, despite some staff being unable to get to work, no visits to people were missed. Staff told us they had sufficient time on visits. One staff member told us, "I get to spend quality time with people, I get time to sit and listen." One person told us, "I'm never rushed, there's

always plenty of time."

The provider had policies and procedures to ensure medicines were managed and administered safely. This included procedures to manage medicines errors. Staff had received medicines training and staff had received further training on medication the day before our inspection. One person who used the service needed help with medication administration. This was because they had been assessed as lacking mental capacity to manage their medicines safely. The provider had identified that this person displayed some behaviours around medication that placed them at risk and had undertaken a best interest decision assessment in line with the Mental Capacity Act [2005]. We saw advice had been appropriately sought from the person's GP and that support had been requested via a referral to community mental health professional. Meetings had been held with the mental health team and that the person's risks around medication had been mitigated through changes to their plan of care. Staff could describe how they completed safe medicines practice including taking the medication out of a blister pack, placing them in a pot for the client to take. Staff described using the Medication Administration Records (MAR) and the process they would undertake, including other medication taken as and when needed. One person told us, "They make sure I take my medication. They come in the morning and give it to me in a little pot."

People were protected by the prevention and control of infection where possible and staff received infection control as part of their induction. Staff were aware of the importance of using personal protective equipment to avoid cross contamination when supporting people and described the actions they took, such as observing regular hand washing and using gloves and aprons when giving personal care. We saw a supply of gloves and aprons in branch for staff to access. People told us that staff observed good infection control prevention in practice. One person told us, "They leave a supply of gloves by the sink." Another person told us, "Oh yes, always gloves and apron."

The provider had systems and process to manage accidents and incidents. There was an accident and incident reporting policy and procedure in place, and these were recorded in a folder along with actions taken. For example, we saw one medicines error recorded which had resulted in no harm to the person, where the member of staff was invited to retrain. Staff told us that under the new acting manager, issues were resolved promptly. One staff member told us, "Absolutely, it gets sorted straight away. We get feedback, there are meetings and conversations, we talk about lessons learnt in staff meetings and supervisions."

Good

# Is the service effective?

## Our findings

People told us they were confident in the skills of the staff to deliver care effectively. One person said, "I trust them and they are skilled in their role." Another person told us, "They know what they're doing." Staff undertook an induction when joining the company which included training specific to the needs of people using the service, such as dementia awareness and mental health awareness. The acting manager told us that essential staff training was up to date, though further training needs had been identified. The acting manager had initiated support from managers and supervisors from other branches to collaborate with staff and share best practice. We saw an action plan to deliver additional training including person centred care planning, document writing and auditing and this was to be delivered within the following month. The provider was in the process of transitioning to a new training program. Staff told us this training was an improvement on previous training, as it was course based and allowed them to progress through a series of programs to develop their knowledge and skills.

Staff told us that they were well supported and had regular meetings with the acting manager. One member of staff told us, "I'm happier now. I get support and guidance from the acting manager, bringing me up to what I should have been doing the last year. Any problems, there's somebody there from management to help." Another member of staff said, "It's better led now, there's more input there, for me and the other staff."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the provider was working within the principles of the MCA. Staff files confirmed that MCA training formed part of mandatory training. Initial assessments prior to people receiving care included whether people could make decisions for themselves. Where people had capacity to make decisions for themselves, they were supported to be engaged in their care. One person said, "I'm very independent and the staff encourage me." Staff understood the principles of the MCA and understood the requirement to seek people's consent for their care. One member of staff said, "I always involve people, offer choices and encourage people. People have a choice to decline." Another staff member said, "Yes I always check, ask them different things, it's their choice." People told us that staff sought their consent before delivering personal care. One person told us, "They always ask before they do anything." Where people may lack capacity, an assessment of capacity was made. Consideration was given to whether people were supported by others to make decisions, such as an advocate or a person with legal authority to do so known as a Lasting Power of Attorney (LPA). A person can have an LPA support them with finance and property matters and/or for health and welfare decisions. Health and welfare LPAs only apply when the person lacks mental capacity to make decisions for themselves around their health and welfare. Staff recognised that when people lacked the capacity to make some decisions, staff must act in their best interests and the person should be supported to make decisions where they can. In one care plan we saw that the provider had undertaken a MCA best interest assessment that was decision specific in relation to the person's capacity to

manage their medicines safely. The provider had appropriately liaised with health professionals and had involved the person's Power of Attorney to ensure a safe plan of care was put in place. The person was supported to be as independent as possible in relation to other matters, such as being involved in activities, socialising and mealtimes.

People chose what they wanted to eat and staff helped to prepare meals if they needed support. Care plans reflect people's nutritional needs. In one care plan we saw a nutritional assessment which highlighted the person had a reduced appetite and needed reminding and encouragement to eat proper meals. Staff told us the person had in the past struggled to manage safe storage of their food and meal preparation, but now staff supported the person with cooking a hot meal by helping them use the oven. Staff encouraged the person to remain as independent as possible by managing the rest of the mealtime themselves, and arranged a welfare check to ensure the person was safe. We spoke to the person and they told us, "They look after me, they help me shower and help me with my food." Another person said, "They help me cook my ready meals and make lovely scrambled eggs."

Staff told us that the team worked well together and supported each other. One staff member told us, "We communicate well, get on as a team. I like working here." Another member of staff said, "There have been lots of changes. Things have improved a lot with communication, training, rotas. It's generally more organised." Staff told us they had effective systems in place to ensure information about the person's care needs and wellbeing was current and shared between other care staff and the office. One member of staff said, "There's a good rapport between us." Staff were encouraged to report any concerns they had, and we saw these were recorded in a folder. Any concerns captured in the out of hours on call book were also addressed. The acting manager told us there were plans to develop into an electronic version where progress on actions taken could be more effectively tracked and managed.

We saw in the care plans that there was guidance for staff around people's specific health needs. We saw one person had been diagnosed with Type 2 diabetes and they had a detailed risk assessment in place. This included guidance for staff around signs to look out for if the person needed medical assistance. Staff told us they knew what to look out for and described the action they would take if they thought the person's diabetes was not properly controlled. People were supported with access to health care services when needed. Staff told us that they assisted people to access support from community health professions. We saw in one person's care plan a referral had been made to the community nursing team when staff noticed a change in the person's skin. A member of staff told us how they looked for any changes in people and any signs of deterioration and what action they would take, "Any deterioration, the doctor needs to know."

Good

# Is the service caring?

## Our findings

People told us they were supported by staff who treated them with kindness and were compassionate and caring in their day to day care. They told us they were satisfied with the care and support they received, they were happy and they liked the staff. The acting manager told us, "The team are amazing – customers first." One person told us, "They are excellent, very good, very kind." Another person told us that since living in the retirement village, they were happy with the care and support, "Everyone is kind and caring in my eyes." A community health professional who had contact with the service told us, "We found them very good" and observed that the person using the service was very comfortable with staff caring for them. Another person told us the staff were, "Kind and caring and helpful." Staff told us that the people working for the service were dedicated and committed to providing good care to people. One staff member told us, "It's not just a job, you do it because you care for people."

People received consistent care from staff that knew them well. Rotas were organised so that the support was provided from a small number of staff. Staff could describe the person's likes, dislikes, background and routines. People told us they were encouraged by staff to maintain their independence and get involved in activities. One person told us, "They encourage me to go out and about" and we saw that the person was independent and active around the retirement village. Another person told us, "There are delightful activities available for us." People were supported to pursue activities and interests that were important to them. One member of staff said, "People are all different, it's their choice, it's about helping them do what they want to do." One staff member told us about one person they cared for, "Anything going on, any activities, BBQ's or birthday parties, she joins in." People were encouraged and supported to be as independent as they wanted to be. One person said, "I'm very independent and the carers encourage me."

When organising support, people were involved in the development and reviews of their care plans. Care plans reflected the person and covered all aspects of their lives including their health, specific risks to them and the person's life history. People's preferences were reflected in their daily routines of care. Staff understood that people's support was based on their individual needs. Staff told us the care plans gave sufficient detail about the person for them to deliver care.

People told us that staff treated them with respect and preserved their privacy and dignity, for example describing how staff always rang the bell or knocked on the door before entering the person's home. People also described how staff ensured their dignity was maintained during personal care. For example, one person told us, "They always ensure the shower door is shut." Staff were aware of the need to preserve people's dignity when providing care to them in their own home and could describe how they would approach personal care. One member of staff told us they, "make sure the bedroom door is closed for privacy, unless she didn't want it closed." We saw that confidential paperwork was stored securely at the registered office.

Good

# Is the service responsive?

## Our findings

Assessments were carried out before providing person care for people and people's preferences were recorded. For example, people were asked their preferred times to receive care. People's emotional and social needs were considered together with their sexuality and religious, spiritual and cultural needs. We saw in one person's care plans that detailed information about their likes and dislikes, hobbies and interests and past profession were captured in a My Life section of the plan and it reflected that the person valued their privacy. Staff could talk in detail about the people they cared for.

People told us that their care and support was planned to meet their needs and they could contribute to the development of their plan. People told us that staff respected how they liked things to be done. One person told us, "I tell them how I like it, and they do their best." Staff told us they understood people's needs and described positive relationships with people and their relatives.

People were happy with the service they received and were asked for their feedback about the care they receive. The provider sent out an annual survey to people to obtain their views on how caring people found the service. People told us they were asked for their feedback via a questionnaire. One person said, "They always send me one of those to fill out."

The provider had a policy and a procedure to manage complaints, including supporting people who lacked confidence or capacity to complain by providing access to an advocate. A person told us they knew how to raise concerns and they were confident their concerns would be responded to. We saw that the service recorded details of complaints separately from people's care plans in line with their policy. One person told us that they had complained in the past and the service was responsive, "Oh yes I would always complain and not let things fester. I did complain and they responded in a timely way." Another person told us they would contact the manager if they had any concerns. People were aware that the service had recently undergone a change of management. Staff told us that under the new management the service had improved in how it responded to people. The care-coordinator told us, "Before I wasn't given the access to have the oversight. Now things are dealt with straight away."

We looked at how the provider had incorporated the Accessible Information Standard (AIS) when assessing people's needs. This is the standard that aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and care services. Providers must identify record, flag, share and meet people's information and communication needs in line with section 250 of the Health and Social Care Act 2012. All organisations that provide NHS care or adult social care must follow the Standard in full from 1st August 2016 onwards. Care plans showed people's sensory and communication needs were being considered and recorded. The service had a policy in place setting out its legal obligations with respect to AIS.

Through discussions with staff, they demonstrated an understanding of human rights principles learnt through the organisational policies. Best practices of how to treat individuals with dignity, respect, fairness, equality and autonomy were explained to staff upon joining the company. Induction training covered

equality and diversity issues. For example, we saw that people were supported to practice their religious beliefs and attend a church service held within the retirement village once a month.

People who used the service were asked about their wishes with respect to end of life care at the time of their initial assessment. We saw that one person was asked about their preferences and it was recorded in their care plan that they did not wish to discuss it. At the time of this inspection the provider was not supporting people with end of life care, so therefore we have not reported on this.

Requires Improvement

# Is the service well-led?

## Our findings

The service did not have a registered manager. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager left the service in June 2018. When we inspected the service, they had recruited a new member of staff to the role who had not yet completed the CQC process to be registered as manager. Cover was being provided by a peripatetic manager who was a registered manager from another branch. For the purpose of this report we have referred to this role as acting manager. The acting manager was supported by the care co-ordinator.

The provider did not meet the minimum requirement of completing the Provider Information Return at least once annually. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We invited the provider to submit their Provider Information Return on 11 June 2018 and the deadline to return the information was 10 July 2018. The acting manager recognised that contingency for this should have been made when the registered manager left the service. We took this into account when we made the judgements in this report.

While systems were in place to monitor the running and overall quality of the service, we found areas that required improvement.

Care plans were scheduled to be audited every six months to reflect changes in the person's care needs. This was not always done in line with the provider's compliance matrix. One member of staff told us, "The care plans need a lot of improvement, with more information about the client, the risks should be clearer. They are supposed to be reviewed every six months – in the past things needed updating, but nothing was done." We saw that some people's care plans were not up to date and contained omissions, for example around guidance for staff to manage behaviour that may challenge, and people's communication needs and medical conditions. We found other examples of good care plan documentation. Where we found inconsistencies, the impact on people was mitigated because staff knew the person well and there was evidence the correct actions were taken. In one example we spoke to a community mental health professional who confirmed the service had acted correctly and was responsive to the person's needs and had maintained their safety. This was an area of practice in need of improvement.

The acting manager was open and transparent with the inspection team regarding these and other areas that needed improvement. The acting manager advised us that the provider had conducted an internal inspection visit in December 2017. This provider visit had identified improvements were required and a support plan was in place. The acting manager was in the process of implementing that plan. For example, they had identified that while essential staff training was up to date, other training was needed. We saw feedback from an audit that had taken place the day before the inspection, which had identified that staff needed additional training in care plan documentation, compliance checks needed to be conducted more regularly, staff files needed more regular audits and staff spot checks needed updating, and an audit of two care plans indicated not all information was up to date and they were not always person centred.

We saw that the acting manager had already taken steps to address these areas requiring improvement. For example, it had been identified that staff would benefit from further medication training and we saw that this had already been acted on. The acting manager also told us that staff supervision and staff spot checks had not been consistent, but we saw evidence that there was now a plan in place for monthly supervision and spot checks. Plans were in place to improve the regular surveys of staff and people who use the service to gather more valuable feedback. While these improvements were being made, time was needed to fully embed the new systems and processes to sustain improvement.

The acting manager was supported by the care co-ordinator. On the day of inspection saw the team were present and actively engaged in running the service. There were five staff providing care and support to people receiving personal care as part of the regulated activity. Staff told us they felt supported by the management team and there were clear lines of responsibility and accountability. Staff described how they had regular meetings which they found useful and we saw evidence of this through meeting minutes every month for the last three months, which showed the team discussed people's care plans, training and medication.

All staff we spoke with told us that changes being made by the acting manager had made improvements to the service. We saw care staff come into the office on the day of the inspection and observed positive interactions with the management team. One member of staff told us, "There have been a lot of changes in the time I've been here, but communication has got better. The last six months things have started to improve." Staff felt comfortable to raise any issues with the acting manager. Staff told us that the management team listened to them, and were responsive to their concerns and ideas. A member of staff told us, "If I've got a concern or suggestion or advice I can share that information. If it helps, everybody's happy." The acting manager had plans in place to further develop the team and build their confidence and told us, "The staff are lovely, they are a really good team, very competent" but explained that they had lacked direction and confidence. The acting manager had taken steps to address this by introducing team events, staff member of the month and letters of recognition. They also had plans to support Dignity Champions within the branch for dementia and diabetes.

The acting manager understood their responsibilities in relation to the Care Quality Commission (CQC) in the absence of a registered manager. The acting manager understood that they were required to submit notifications to us, in a timely way in accordance with the requirements of their registration..