Routes Healthcare (North) Limited

Routes Healthcare Rochdale

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection of this service took place on 13, 14 and 15 June 2018 and was announced.

Routes Healthcare Rochdale is a domiciliary care agency providing personal care to people across the north of Greater Manchester in their own homes. It is registered to provide personal care and treatment for disease, disorder and illness. The service provides excellent services to children and adults with complex health and social care needs. Services include 24 hour support; up to five domiciliary visits a day, a night sitting service and carer breaks. When we inspected, the service was supporting 131 people. However, this figure could change on a daily basis, as they supported a large number of people who were on an end of life care pathway. The service provides an extremely efficient and speedy response to requests to 'fast track' people at the end of their lives to return home from hospital so they could spend their last hours and days in the comfort and familiarity of their own homes and allowing them respect and dignity in their final days.

This was the first inspection of Routes Healthcare Rochdale since they moved to their current premises. At a previous address the service was last inspected in February 2016 when it achieved a rating of good overall, with outstanding in care. At this inspection we found the service continues to maintain and improve standards.

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 service did not have a registered manager at the time of our inspection. Services without a registered manager cannot be rated as 'Good' in the well led section of our inspection. We were told that a new manager had been appointed and started the registration process. An area manager had taken responsibility for the day to day management of the service and to ensure a smooth transition to the newly appointed manager. This person was supported by a Deputy Manager who was on leave on the days of our inspection. Both the area manager and the nominated individual were present during the inspection. They told us that they were keen to ensure that the service recruited a registered manager who had the appropriate managerial know-how and the clinical knowledge and understanding to meet the complex needs of the people supported by Routes Healthcare, and wanted to ensure the right person was recruited.

Training opportunities for staff were exceptional, with consistently high-quality training provided to all staff. Bespoke training was delivered face to face by people who knew the issues and risks involved in supporting people with diverse and complex social care needs, and specialist training was provided for staff who were working with people who had complex or life limiting illnesses, so that they were able to use specialist equipment and monitor, manage and minimise any risk to the individual.

Care staff demonstrated an exceptionally caring and enthusiastic approach to meeting the needs of the people they supported. They were kind and considerate of people's needs and abilities and were prepared to go the extra mile to ensure needs were met, and that the people they supported were comfortable. There

were many examples of how their caring outlook had a positive impact on people's lives.

Care plans showed really good attention to detail and were flexible to meet day to day changes and changing needs. This meant that care staff could arrange with the people they supported to spend less or more time with each person they supported, depending on their needs on the day.
Care records contained important information about people and daily records were clearly written and gave detailed and factual accounts of each intervention.

To ensure staff maintained high standards when delivering care, regular spot checks were undertaken, and staff received regular supervision. They told us that they found supervision informative and instructive. They told us that their managers and supervisors were helpful and always available to speak to if they had any concerns. The service operated an on-call system to allow staff to contact a member of the management team in case of any emergencies.

Staff were supplied with appropriate equipment to prevent the spread of infection, including disposable gloves, aprons, and facemasks to minimise the risk of airborne germs. Good systems were in place to manage and administer medicines and reduce the risk of errors occurring.

All the staff were aware of how to protect people from abuse, and well trained to ensure their safety. We saw that where a risk or potential risk was identified, comprehensive care plans were designed to minimise the risk as they applied to the person who was being supported. They were personalised to each individual and recognised their right to take personal risks. All the staff we spoke to understood issues around mental capacity and people were offered choices in how their care was delivered.

Staff were safely recruited. People who used the service were involved in selecting staff, and the service considered people's needs and wishes, looking to recruit people who shared similar backgrounds and culture People told us that they were supported by regular and consistent staff, and that they liked that the staff who supported them always worked in pairs, as this allowed the staff time to talk and listen to them.

We saw that the service had developed good systems of communication, including regular team meetings. Staff could access a Routes Healthcare app on their mobile phones so they could access up to the minute information about the service and receive text messages relating to their work. They had set up their own 'Routes TV' channel on the internet to provide guidance and advice to staff working in the field and to access any information they might require.

The provider had up to date complaints and whistleblowing policies and procedures which gave information for staff to follow and time scales to adhere to. This helped to assure people and caregivers that their concerns were taken seriously and addressed quickly. Quality assurance systems were in place and used to monitor the quality of service people received, and good systems were in place to monitor day to day management of the service. The management team had adopted an inclusive management style that supported staff and increased their confidence in working with people who had complex health and social care needs. Staff felt well supported. Staff turnover was low which meant that people who used the service were supported by people who knew them well. Where they had identified risks with the recording of medicines they used this as a positive opportunity to revise their medicines procedures to ensure that the risk of medicine errors was minimised.

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.

Staff understood how to keep people safe, and understood and reported allegations of abuse.

Good recruitment procedures ensured only suitable staff were employed by the service.

Detailed and robust risk assessments were developed alongside the people who used the service to identify and minimise any risks.

Is the service effective?

Outstanding

The service was extremely effective.

The service provided outstanding training opportunities to new and experienced staff to ensure they delivered good person-centred care.

The service consulted and worked with health care professionals to assist people to receive ongoing high quality health care.

Consent to care and treatment was always sought. Where they were unable to consent, appropriate decisions taken on behalf of people were made in their best interests and took the views of people close to them into consideration.

Is the service caring?

Outstanding

The service was extremely caring.

People were supported by staff who were committed to providing high quality care and had an excellent understanding of their needs and wishes.

The area manager and staff consulted and worked closely with people and their families to ensure they were always actively involved in all decisions about the care being provided.

Care staff were not restricted by time constraints and people told us staff were attentive to their needs.

Privacy, including personal information, and dignity were valued, and people were treated in a caring and compassionate manner.

Is the service responsive?

Good

The service was responsive.

The service was flexible in approach, and staff were confident when working with people with complex health needs.

Care and support was reviewed and monitored in accordance with people's changing needs.

The service could respond quickly to support people in their own homes at the end of their lives.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was no registered manager in place.

People, their relatives, staff and appropriate professionals expressed high levels of confidence in the management and leadership at the service.

Extensive quality assurance systems were in place and fully utilised.

There was a strong emphasis on the service to continually strive to improve.

Routes Healthcare Rochdale

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 inspection took place on 13, 14 and 15 June 2018 and was announced. We gave the service 24 hours' notice of the inspection because it is a domiciliary care service and we needed to be sure that someone would be in the office.

The inspection team consisted of one inspector and an assistant inspector. Before this inspection, we reviewed notifications that we had received from and about the service. This included statutory notifications, which are notifications the provider must send us to inform us of certain events. We had received a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well, and improvements they plan to make. We contacted the local authority and health commissioning teams who were responsible for organising and commissioning the services on behalf of individuals and their families. This was to seek their views on how they felt the service operated. All provided positive feedback.

During this inspection we visited and spoke with four people who used the service and contacted five by telephone. We also spoke with six relatives. At the main office we spoke with the area manager and nominated individual, two nurse leads, two team leaders, a healthcare assessor and five care assistants. We reviewed eight people's care records, nine staff records, and four medicine administration sheets. We also looked at other documents and records about the service, such as audits, quality assurance questionnaires and training records.

Good

Is the service safe?

Our findings

When we asked, people who used the service and their relatives told us that they felt safe with the support and care provided by Routes Healthcare. They told us that staff were mindful of their security, and where people were unable to answer their doorbell, key safes were in place and codes were provided only to the people who required them, and kept securely to prevent any unauthorised access.

When providing care, people told us that staff were careful to avoid any undue harm. A relative told us how staff took care when moving their relative, telling us, "They have thought of ways to protect [my relative's] knees, and build up cushions. They are always thinking of ways to minimise the risk". A person who used the service talked about practical support: "I feel safe when they are around. If I'm feeling a bit wobbly they take their time." Staff were trained to use equipment. A relative told us, "They visit four times a day, they all know how to use the equipment, and take a lot of care when they are providing support". This person went on to say that regular staff also provided a 'sitting service', which allowed the main carer time away from their caring duties, telling us, "I trust them when I'm not around. They are all very good, I've no problems at all: they all know what they are doing".

Staff had access to the service's safeguarding policies, were aware of the procedures and understood how to use them. They told us they had received training about protecting people from harm and we saw in the training matrix that all staff had completed training in this area. We looked at the service's safeguarding files and saw that where alerts or concerns had been raised, appropriate action had been taken to protect the individuals concerned.

The staff we spoke with demonstrated a good understanding of the need to protect people from harm, and were able to indicate different types of abuse. One care worker told us that all the people they worked with were vulnerable and that due to their circumstances they were liable to exploitation. They told us how they had reported an allegation of financial abuse by a third party which led to a successful prosecution.

We saw in staff records that where issues of poor conduct were raised either by staff, people who used the service and their relatives, or through observation of practice, these were dealt with appropriately through the whistleblowing and disciplinary procedures.

Routes Healthcare worked with people with profound and complex medical needs, and ensured that clear and robust risk assessments had been completed with them and their relatives to enable staff to safely promote and maintain people's independence. Nurses employed by the service completed in-depth risk assessments for each client outlining the risk and actions to minimise any risks identified. Individual assessments were specific to the person and took their views and wishes into account as well as their physical, emotional, and cognitive ability, and considered any environmental factors. For example, in one file we saw detailed risk assessments and contingency arrangements were in place to allow for continued care in the case of power failure, or failure of vital equipment. Assessments recognised the risk particular behaviours might pose to other people who used the service, and provided clear and detailed instructions to help 'distract' or help the person to engage in activities. This showed that areas of potential risk had been

assessed, identified and appropriate action identified to help reduce or eliminate the risks to the person and other people. Care workers understood and followed care plans to ensure people remained safe. One care worker stated, "We have risk assessments for our safety as swell as theirs. I don't cut corners, equipment is there for a reason. You have to reassure them. Do the job right, that's what I believe in."

The service employed enough staff to adequately meet the needs of the people they supported. Most of the people who were supported by Routes Healthcare required two members of staff for support during day time visits, so care staff always worked in twos. This ensured greater safety, consistency and provided time to spend with the individual rather than focussing on the required tasks.

When asked if there was enough time on visits care staff told us that they, "We're not time consumed". One stated that there was always enough time, but, "If [there isn't] we stay anyway, you can't rush a client." They went on to say that in those instances they would let the office know so that other people on the run could be informed that they might be late, or alternative arrangements could be made. They informed us that there are regular checks on times and that all times are documented. The area manager told us that if the person required more or less time, that they would negotiate with the commissioners of the service to amend the contracted hours.

People supported by Routes Healthcare were encouraged by the service to take responsibility for their own medicines but where they required assistance the service had developed robust systems to ensure that medicines were administered safely. One person who used the service told us, "I have a lot of medicines but they always check and tell me what they're giving me." They told us care workers would check before they administered and count the medicines at each visit to ensure the right dose had been given.

A recent internal audit of medicine procedures had identified issues around administration of medicines, particularly where care workers shared responsibility for administering medicines with family carers. The service had revised the policy to ensure that either one or the other took responsibility. This reduced the risk of over medicating and ensured clear lines of accountability. In addition, the service had designed their own Medicine Administration Record Sheets (MARS) to make a better fit with care delivery and reduce risk of medicine errors. We looked at four MARS and saw that they provided detail to ensure medicines would be administered safely. Records were sent to the main office and audited on a monthly basis. All staff received thorough training on medicine administration and the service had produced a short film with instructions available to staff whilst on the job through a YouTube internet channel which they could access using their mobile phones.

Systems in place protected people and staff from infection and cross infection. All staff had attended infection prevention and control training. Staff we spoke to clearly understood the importance of infection control measures, and that the people who used their service could be more susceptible to infection or illness due to the nature of their condition. They were provided with face masks if necessary to minimise the risk of spreading airborne disease, but one person who used the service told us they had to ask a carer who was unwell to put a mask on and, "It doesn't come automatically to them".

Throughout our inspection we saw examples of an open and transparent culture. Staff told us that they were encouraged to report incidents and concerns, and people who used the service said that if they had any issues, that these were promptly dealt with. The service saw complaints as an opportunity to improve the quality of service delivery, and a service user survey encouraged people to suggest improvements. Where suggestions had been made there was evidence that the service had responded, for example where one person said that they became anxious about the time of visits from care staff, the service had initiated a system to let them know when the staff would arrive.

Outstanding ☆

Is the service effective?

Our findings

All the people Routes Healthcare supported lived in their own homes, and had very complex health and social care needs. They could either self-refer or had been referred by commissioners such as local authority care services or health commissioners. Bespoke packages of care to meet and go beyond assessed need included 24-hour care and support, day time care and support, a night sitting service and daily visits (up to five visits each day). They also provided a sitting service to provide people with a break from their caring responsibilities. They provided detailed packages of care to children and adults who had a variety of diagnoses, such as acquired brain injury, motor neurone disease, progressive Multiple Sclerosis (MS), or Muscular Dystrophy. They provided care and support to people who were receiving palliative care and the service also provided end of life care and would support people being discharged from hospital on an end of life care pathway. One of the registered nurses employed by the service told us that they could assess and fast track end of life packages to arrange a care package to help a person return home to die within a matter of hours if necessary, and some care packages could be in place for less than a day due to the severe and terminal nature of their illness. When we spoke with service commissioners and other professionals they all told us that Routes provided an extremely effective quality of care, and one commissioner told us that in an emergency they could rely on the service to provide a fast and efficient response. Care staff had the knowledge, expertise and support to deliver high quality care to people who were terminally ill. This meant that they could plan and provide end of life care at a moment's notice for people who wanted to be discharged from hospital to die in the comfort and familiarity of their own home.

Routes Healthcare worked in partnership with other organisations to ensure high quality care was consistently provided. We spoke with the relative of one person who used the service. They told us the person they supported had been discharged home from hospital six months previously with anticipatory medicine for end of life care as they were expected to live for only two weeks. However, the care and support the person received had provided a good quality of life, and the service was working closely with health professionals to ensure all needs were being met. When we looked at care plans we saw evidence of close liaison with health professionals including doctors, consultants, physio and speech therapists and dieticians. One care plan where a person was at high risk of developing pressure sores showed body maps were completed at the first sign of risk, regular consultation and support from a tissue viability nurse. Another care plan for a person who received 24-hour care from two staff for support with their tracheostomy, ventilator and catheter showed regular reviews involving health and social care professionals. Trained care assessors assessed any person who might require support from the service, liaising with health professionals to ensure the service could deliver the highly complex social and health care needs of the person. This included fast track end of life care packages. They also conducted comprehensive reviews of care needs and provision every nine months inviting health professionals who may be able to contribute to providing appropriate care and advice to maintain the best health.

The service had identified pioneering approaches to care and support. the service had introduced speech communication aids to help non-verbal people to speak with staff. Effective use of technology, such as software to operate home equipment like radio, TV and computer assisted people to remain independent. A 'People Planner' software system supported the service to match care staff to the right client, ensuring that

they had the appropriate knowledge and understanding to provide effective and safe care.

The service had set up a YouTube channel called 'Routes TV' available on the internet to provide staff with instruction and keep abreast of any changes they may need to be aware of, such as changes in mental capacity guidelines. We watched one programme which provided step by step instruction around administering medicines. One care worker told us "It's really useful. If I'm in doubt I can check on my phone to make sure I'm doing it right. If I'm still not sure I can always ring the office for advice".

Care assessments put the person at the centre of their care. They reflected their current situation, what 'I am able to do for myself' and 'What I would like [the service] to do'. This ensured care plans were inclusive and empowered people who used the service to remain in control of their care plan.

We asked people who used the service and their relatives about the knowledge and skills of the staff team. They spoke highly of the staff and told us that Routes provided a high standard of effective care. One person told us, "I'll never go into a care home. This is where I'll stay whilst I've got the support from Routes".

Staff told us that they had access to excellent training opportunities. They told us that they had received a wide range of training in areas such as safe holding, choking risks, and catheter care. We saw the service provided excellent training and development opportunities to ensure all staff could consistently deliver a high quality of care. All staff new to care completed the care certificate, which is a nationally recognised qualification designed to equip staff to deliver all aspects of care. In the Provider Information Return (PIR) the area manager informed us that staff completed a minimum of 10 training modules before working with people who used the service to ensure that they had the baseline knowledge to meet the standards of care required by the company. The training records we looked at showed staff had exceeded this number. Much of the training was classroom based; a healthcare assessor told us that training such as first aid or moving and handling could only be delivered in the classroom. The service also recognised that training could be delivered electronically, and staff told us that this was, "designed to really test you; the questions change every time so the message sinks in". All the staff we spoke with demonstrated a strong clinical knowledge and an ability to work with highly complex packages of care. This meant that the service would meet people's needs to highly specialised care specifications.

Training recorded in staff files we looked at included training certificates for completed courses. We were also shown the 'My Learning Cloud'. This is a bespoke system which Routes use for training. Learning pathways were set out for each member of staff including complex care or staff who received PEG (a PEG is a percutaneous endoscopic gastrostomy where a tube is passed into a person's stomach to provide a means of feeding when oral intake is not adequate) and cough assist training. This was monitored electronically and when any training was due, or needed to be refreshed an email would automatically be generated to alert the person's supervisor and a message sent to the person's mobile phone.

A health care assessor told us, "The 'safety of the client is paramount." They told us that where staff were working with people who had complex or specific needs further bespoke training was provided, for example, tracheostomy care, PEG feed care or caring for people on ventilators. We were told that where possible, people who had bespoke care needs were invited to be involved in planning and delivering training to staff. This meant that the staff who delivered their care would understand how the care they provided made a difference to the person they supported. We also saw that family members were also invited to training provided by Routes Healthcare, such as administration of medicines. This helped ensure consistency and safe care and support for people who used the service.

Once new care staff had completed their training modules they would work with an experienced member of

staff and shadow them throughout their work schedule. They would be monitored and observed, completing a 'due diligence' check, and following a competence test they would be able to take the lead with people they supported. One person who used the service told us that recently a new person was introduced, and was shadowing a more experienced care worker. They told us the main carer was very good at explaining the person's needs and involved the person in explaining how and why they worked in a specific way.

The service had set up a team known as the 'Excellence in Care' Team, some of whom had worked as care workers for Routes Healthcare, and had experience of working with the people supported by the service and could pass on their knowledge. Not only did this provide staff with the opportunity to seek alternative career pathways within the care service but it also allowed training to be built around the specific needs of the people they were supporting. A health care assessor told us, "We can use our experience in the training room - good and bad." They service had developed the Excellence in Care' course, which the health care assessor explained took carers 'back to basics' and covered all aspects of their role. A group session of approximately 10 members of staff discussed topics such as legislation and body maps. A practical session, which the assessor described as a "big ball of fun" focused on person centred care and dignity and respect. It used mannequins to demonstrate how to perform personal care such as brush teeth, shave, mouth care and catheter care, and reminded staff of the fundamentals of delivering care. They also used a model of an ulcerated foot which showed the four stages of pressure sores and care staff were asked to describe each stage. The course ended with evaluation notes and the care staff were required to write all the tasks down making sure that they have expanded enough and that it was factual.

The "Excellence in Care" course had been designed to improve the overall quality of care and improve the confidence of staff. All staff were obliged to attend this course to ensure that their knowledge and understanding was kept up to date, and that they did not get 'stuck in a rut'. One care worker told us that when they last attended the course, there was a lot of discussion around discrimination and what behaviours and actions are unacceptable, and that this ensured that everyone is treated fairly. The bespoke learning programme for all staff had been mapped to units from the Qualification Credit Framework Diploma in Health and Social Care and provided staff with the knowledge and skills required to deliver the highest standard of care. This meant that care was delivered to a consistent and high standard by all the care staff.

Informal 'lunch and learn' sessions were arranged on a regular basis. When any changes in procedures were implemented, or when there where topical issues, staff were invited to have lunch in the head office and attend a learning session. There was a register showing that 24 members of staff had recently attended lunch and learns on medicine training. The training materials included clear guidelines on filling out medicine administration (MAR) records, why it was important, units of measurements, a copy of a MAR chart audit and an example of a completed MAR. No people who used the service were visible or identifiable, which ensured that confidentiality and anonymity was maintained. Notes from the lunch and learns showed positive feedback from staff.

All staff had a yearly appraisal which gave them the opportunity to reflect on their work and set targets for the following year. They received a formal supervision session every three months, either face to face or by telephone, with additional sessions more frequently if required. We looked at nine staff records and saw supervision meetings provided staff with an opportunity to speak in private about their training and support needs, as well as being able to discuss any issues in relation to their work. There was evidence to show staff used the opportunity supervision provided to reflect productively on improvements to meet need. Planned supervision sessions asked staff to reflect upon their performance and needs before the meeting with their supervisor to ensure that the session was productive. In addition, senior staff would conduct spot checks

where care workers could be observed delivering care and support. At each check, any issues were addressed, staff were given constructive feedback and signed to say they agreed with the checks made.

When we looked at care records we saw that attention was paid to healthy eating, and any dietary needs, either medical or cultural, were taken into consideration. Reference to Speech and language therapists (SALT) indicated consultation and instruction regarding swallow or choking issues, and instructions were followed to maintain people's safety. Where staff assisted people with food preparation, or provided meals, people told us that the quality of the food was good.

Throughout our inspection we found evidence of good communication amongst staff, who worked collaboratively to ensure a consistency in approach and attention to detail. The daily records we looked at were clear, concise and factual and gave an indication to the next person visiting of any issues they may need to address. Staff told us that they received a handover using their phones to communicate any concerns. This allowed continuity of care and alerted staff to any concerns or issues to be addressed. Regular meetings were held for care co-ordinators, specific teams or for the whole staff to ensure consistency and good quality was maintained. These meetings were minuted, and minutes showed that staff were involved in discussions and their views were taken into consideration.

We saw evidence to show Routes Healthcare kept up to date with new guidelines and research to ensure that services were delivered in line with legislation and best practice. For instance when we asked why care plan templates were 'version 13' we were told that plans were revised and updated to reflect any changes in guidelines so recent changes reflected changes to mental capacity rulings, and changes to medical guidance issued by the National Institute for Clinical Excellence (NICE). Further changes had been made when the service liaised with falls co-ordinators and tissue viability professionals to ensure that their practices remained up to date. We were told that the service also contributed to the development of best practice within other services, for example, we were told the nominated individual and other staff had recently exhibited at a conference organised by the British Association of Brain Injury Case Managers (BABICM)

The service worked closely with partner agencies to ensure that care was effective and person centred. We were told that the service liaised with the clinical commissioning teams on a daily basis, and commissioners had attended review and multi-disciplinary team meetings. One commissioner we spoke with confirmed this. This had led to good cooperation between agencies, for example to agree a care plan to allow one person who had been a smoker all their life to continue to smoke with support from staff, minimising the risks involved with the use of oxygen. They also liaised closely with hospice staff to cover 'last minute' changes to need both in the hospital and community.

As part of the medicine procedure staff were also provided with instructions to 'look and listen' for any slight changes of early warning that all is 'not quite right'. We were told, and saw in daily records that staff remained vigilant to any changes in a person's appearance and would report any concerns immediately. For example, one care worker noticed a person had a slight rasp when they were speaking and this was reported to the person's doctor, who followed up with a visit and prescribed antibiotics.

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.

We checked whether the service was working within the principles of the MCA. Consent was sought as required for all aspects of support offered. The staff we spoke with told us that they had received "really good" training around consent and capacity and were able to demonstrate a sound knowledge of the issues of providing care to people. They discussed issues where the person they were supporting may have to make their own decisions which may be contrary to the person's relatives, and told us that they understood and supported people's right to make their own decision. For example, one member of staff told us, "There have been occasions when we have not got clients out of bed on the morning call because the client did not want to get up. The families often want you to but we are there for the person firstly, it's their decision, not [their families]". When we reviewed one care record we saw extensive information regarding a person's fluctuating capacity, and how this related to a life-threatening condition. The service had researched the risks and were able to discuss this in terms the person understood to help them to reach a fully informed decision about the risks involved with their choice.

All the care records we reviewed included signed consent where possible to say that the person agreed to receiving care and treatment. Where it was suspected a person lacked capacity to consent to care and treatment, capacity assessments and best interest forms were completed and kept in the person's notes. We saw that where this was the case best interest assessments were completed, and included the views of family members and professionals involved in care. For example, we saw best interest forms for personal care, PEG feed, care at home, and administering medicines. The forms included records of discussions with people consulted, including family members, and the rationale for the decision reached.

People and their relatives told us that the care staff always asked for permission before they provided care, and one person told us that they had asked them for permission for a National Vocational Qualification assessor to visit the home to assess the carer. Another told us, "They want to be supportive. They know [my relative's] ways and understand how he will want support, but will always ask and check".

Outstanding ☆

Is the service caring?

Our findings

One person who used the service said, "All the carers are lovely. They always greet me and will go out of their way to do anything for me. We also have a great laugh together and I know they care about me."

When we inspected this service in February 2016 we rated caring as outstanding and during this inspection we found that the service had maintained the high standards it had set. Prior to this inspection we sent a questionnaire to people who used the service. Out of eleven replies, ten people agreed or strongly agreed that staff 'always treated them with respect and dignity'. During our inspection we received extremely positive comments from the people we talked to about the attitude and approach of staff. One person told us, "The staff who support me are dedicated. They really show how much they care". People told us that they involved them in all tasks, explaining what they were doing, and why; "They are kind and caring. There is always good banter, and they always tell me about my tablets, what they are for and why I take them". A relative commented, "They are very patient. [My relative] can sometimes be very aggressive but they stand back and give [my relative] all the time he needs. They are very patient and kind".

We saw that daily rotas were organised in a person-centred way; they provided only the name of the person and the amount of time commissioned to meet the needs of the person. Care workers could then negotiate the times of their visit with the person; one told us that they prioritise accordingly to the person's needs and wishes, and aim to give people the times which they like in order to deliver a continuity of care. Staff were employed to work on specific 'runs' based on a geographical area.

The area manager told us that there was good staff retention, but when a new person was recruited to a particular run they would shadow a regular member of staff so they could be introduced to the person. One person who used the service told us, "Sometimes you can get someone you don't know, but they are accompanied by a person you do. Sometimes they'll stay a bit longer to sit and talk, so I can find out about them and they can find out about me".

Although recruitment was centralised, the service used a 'people planner' so new staff could be matched appropriately to the people they would support. Staff were recruited carefully to meet the needs of the people who used the service. Attention was paid to selecting the appropriate candidates, involving people who used the service to ensure that new recruits were compatible, could share similar hobbies and interests and develop a healthy relationship with individuals. The area manager described how they had supported a person with profound disabilities to select the staff they wanted to work with them. This meant that people were supported by care staff who shared similar backgrounds interests and culture. Appropriate checks were made on all candidates, including references, criminal records checks, proof of address, identification and rights to work in the UK. Any gaps in employment were accounted for, and if people were required to cover night sits a further medical check was undertaken to ensure their capability. This meant that only suitable people were employed to work with vulnerable people.

We spoke with two care staff who had previously been supported by Routes Healthcare when care was either delivered to their relatives, and observed care from a professional viewpoint. Both told us that they

were so impressed with the quality of care their loved ones received from Routes Healthcare that they told us they wanted "to give something back", and had successfully applied to join the company. Other care workers told us, and this was confirmed by the people who used the service, that they had developed an excellent rapport with the people they supported. A care worker told us, "You've got to have heart and soul for this job; we get to know the people and their families well and we have enough time to see and talk with people". At the same time, they recognised that as part of their role they were required to be friendly but remain professional. A health care assessor told us, 'I miss working with people who use the service, you become very close, but I recognise there are boundaries". They told us they can still provide the support by ensuring that good standards of care would be maintained.

A health care commissioner we spoke with told us they believed the service was person-centred and people supported by Routes Healthcare were fully involved, consulted, and involved in any decisions about their care. We saw that the needs of the people who used the service were foremost, and people were treated with kindness and patience.

Staff worked either on domiciliary care 'runs', each with a small number of people supported by the service, or were employed specifically to work with one person who used the service. This provided consistency and allowed staff to know and build up relationships. We spoke with one person who used the service who told us, "I get the same faces, and have got to know them all individually. They are all great!" When we spoke with care staff they described with enthusiasm how they supported people who used the service and spoke fondly of the different personalities of each and how they adapted their approach to provide a person-centred response to each person they supported. For example, one carer described how a person they supported liked to "have a laugh and a giggle", and another was "proper old school", and liked their care to be delivered in a more formal manner. All the staff we spoke with could identify and work with the specific traits of the people they supported and respond in a person-centred way.

An equality, diversity and human rights approach to supporting people's privacy and dignity was well embedded in the service. Before working in the field all care staff undertook an 'ethos values' training module, which they needed to pass with 100%. This covered all protected equality characteristics. Staff were recruited to reflect the diverse nature of the community, and we saw that they were matched to people who shared the same cultural values, and were able to communicate effectively, often in the person's first language. For example, where children were supported by the service, care was taken to ensure staff shared or understood the cultural norms of families. The service employed a high Muslim staff base, and recognised that work commitments can be interrupted, for example during the month of Ramadan. Rotas were planned and scheduled in advance of any specific cultural or religious occasions to ensure religious observance could be practised and alternative plans put in place to minimise disruption.

We were told that the first language of one person who used the service was not English, so a care worker who spoke the same language was recruited specifically to work with this person to enable excellent communication and reduce the language barrier. Where people had difficulty with speech, for example, if they had a brain injury or disease such as motor neurone or MS which affected their ability to communicate, the service used speech recognition tools and assistive technology to enable clear communication. Written information was available in different formats or large print if necessary.

When we asked the nominated individual and area manager how the service ensures people get the support they need and want they gave examples. One person became bed bound and was unable to afford an appropriate bed. The care coordinator advocated on their behalf to arrange for a bed to be provided which would allow safe delivery of care, and once this was agreed they arranged to deliver the bed free of charge. We saw people were supported and encouraged to have as full a life as possible, for example, support to

attend concerts, football matches and other outings. One person had been supported to obtain a coveted spot working as a disc jockey at a summer festival. Staff did not see people's disability as a barrier to participation and considered their background and culture, supporting them to maintain interests in common with others of similar age and background. The head office displayed extremely good mouth paintings by one paraplegic person supported by the service. The area manager spoke with high positive regard about this person and told us how staff supported this person with all aspects of daily living including attending sport and cultural events, telling us they promoted their 'fantastic life'.

People and their families were supported to explore sources of additional help and advice. For example, we were told how one person had been helped to research information about their condition. To ensure another person could keep their pets although no longer able to look after them, the service supported them to liaise with the health commissioners and a local vet to ensure the care package would include support so that they could have their pets close by as they approached the end of their life.

At assessment if environmental safety concerns were identified, the service would signpost the person and their family to where sources of help, including pendants and call alarms could be provided, and inform the commissioners of any suggestions. The service also supported staff to seek advice and support, and offered six counselling sessions to staff free of charge to assist them with bereavement.

Flexible rotas meant staff could spend more or less time with individuals depending on their needs at each visit, so staff were not constrained by time restrictions and they told us that they always had enough time to meet people's changing needs. They said that they did not feel rushed for time when supporting people and were able to stay longer with a person if they needed to. People spoke fondly and positively about the attitude and approach of staff. They told us that they were always polite well-mannered and patient. One person said, "They are brilliant, fantastic. All are very good and nothing is ever too much trouble". Another told us, "They are very flexible, and always here for me". They go the extra mile and do the extra bits some care companies won't do, like they'll get me eggs and spuds, or bring in a newspaper for me to read when they've gone". This person also told us of a recent incident when district nurses had forgotten to order medicines. The care workers arranged for the medicines to be dispensed and for the prescription to be delivered.

We asked staff how they would respond to an emergency, and they gave examples of how they had supported people who were in difficulty. For example, one care worker described a call where they were unable to roll a person, who was lying in bed, due to the amount of pain they were in. They stayed at this call for over two hours whilst they tried to help. The person was in a lot of pain and did not like taking traditional medications. They ensured the person was safe and comfortable. They contacted the main office, who arranged for any later visits, and contacted the hospice who came to provide extra help and support for the person.

Respect for privacy and dignity was embedded in the culture of the service, and staff explained how they would maintain people's dignity for example, when supporting them with personal care tasks. Many of the people supported by the service had returned from hospital on the end of life care pathway, and care staff recognised the distress this could cause, and worked to provide compassionate and empathetic care to the person and their relatives, ensuring that their wishes were respected and that any sensitive issues were treated in a dignified way. One person remarked, "The care workers are also very pleasant. The humour they all have makes any embarrassment disappear".

We saw this extended to records and personal information held about people. Staff had signed confidentiality agreements and information held about individuals was stored safely in people's homes.

Records were factual, and could be checked by the people who used the service. Information held centrally was secured in locked cabinets or on password controlled electronic systems with further security for more sensitive data. This protected the confidentiality of both the people who used the service and the staff.

Good

Is the service responsive?

Our findings

The service commissioners we spoke with believed Routes Healthcare provided an excellent service, and one person who was supported by the service endorsed this, telling us, "If it wasn't for [Routes Healthcare] I'd be in a real mess. They've been a godsend".

The service recognised that people had varying needs and provided a person-centred approach to care provision, responsive to need. Prior to receiving a service, clinical lead nurses employed by the service would undertake a thorough initial assessment, taking into consideration the complex clinical and social needs of the individual with consideration of how best to manage risk. Assessments were used to form the basis of a robust and comprehensive care plan with sixteen specific areas covering all clinical social and aspects of daily living issues, including medical issues, communication, mobility, nutrition and fluids, emotional well-being and social inclusion. Plans were person centred; for example, we saw an entry which read, 'Staff should ask [person] daily if [their] towels need to go in the wash as this is her choice.' Another provided person-centred information about a person's wishes: 'Sometimes doesn't wear her dentures as [person] likes to save them for best.' Care plans were very easy to follow and well referenced. They were broken down to provide staff with clear and detailed instruction to ensure that the delivery of care was in accordance with people's preferences and wishes. For example, we looked at a plan around moving and handling, which made specific reference to different types of transfer required, such as from bed to chair, or into their car. Where possible, people were involved in planning and reviewing their care, and plans indicated people's abilities as well as their individual needs. People we spoke with told us this was reflected in how they received assistance; one person told us "I try to do things for myself. They are here for support and they encourage me" They told us that staff would, "Help me to get into the shower and help to wash my back, but they are not intrusive and let me do things. They help put things in the washer, but I can work the cycle myself".

Care records included a short profile section which included details of the person and an up to date photograph, for which consent had been obtained, showing that the person had been consulted about their care needs and agreed to the way these needs were met. A section in each care record entitled 'All about me' gave a person-centred view of the person, their background and history, their likes and dislikes and any activities or hobbies. This meant that anyone unfamiliar with the person would be able to gain a clear understanding of the person, their needs, their lifestyle choices and their value base.

Where people were supported throughout the day or on a 24 hour basis, care plans referenced their interests and any social and educational activities, and staff supported people with these. For example, one care plan indicated support for a person to attend full time education detailing the care needs staff would need to undertake to ensure full access to education. People told us that they were supported to maintain their hobbies and interests and lead a full and active life. This was reflected in the daily notes we looked at, and in conversation with Routes Healthcare staff. Daily notes and records of interventions written by care staff during each visit provided a good description of any activities or tasks undertaken, and gave a factual account of the person's mood and demeanour. This provided a running chronology of the interactions with people supported and could be useful in pinpointing any changes in need.

Where specific health risks had been identified, such as the risk of choking or the need for medicine suctioning, staff were given appropriate training and knowledge to manage risk or refer to other health care professionals as required. For example, staff were trained to an appropriate level in tracheostomy care, bowel and bladder management and other specialist issues. Care records documented regular consultations with a variety of healthcare specialists to ensure that people were supported to maintain good health and ongoing healthcare support. These plans were updated and action points noted, for example, referral to a dietician, with the specific reason documented.

Where specific communication needs were identified, the service provided information in alternative formats such as easy read, and could provide information translated into other languages if this was required.

Regular reviews of care were undertaken, including a three-monthly review by the care co-ordinator and a full holistic review involving all people involved in planning care was convened by the clinical lead nurse. People and their relatives told us that they were always involved in the review, and one relative told us, "I am asked to contribute to the care plan. They are very nice and supportive to me but I know [my relative's] needs come first." We saw records of care reviews included feedback from the person, any comments and changes in care delivery, and actions needed to improve care and support.

Many of the people supported by Routes Healthcare were receiving care at the end of life, or had complex health needs. Their needs could vary from day to day, or even hour by hour. This meant that care staff needed some flexibility in how they arranged their daily work schedule. Care plans did not specify specific times for visits, unless there was a specific need such as administering medicines at a specified time during the day, but gave a general idea for morning, lunch, afternoon teatime and evening calls. Care staff would negotiate with people they supported when they wanted their care, and prioritised those people most in need. People who used the service understood that their needs may not be greatest, and were willing to accommodate some flexibility. One person told us, "I don't expect them to arrive at the same time each day, they deal with some very poorly people., and can often get held up with them. Sometimes they need to stay with me a bit longer, if I'm having an off day. If they are very late they always let me know. This meant that they could be flexible and respond to any changes in need. The drawback to this, however, was that the service could not stick to specific times, or guarantee that the time of visits would coincide with other people's schedules, such as district nurse visits or personal assistant visits. One person told us that, although their care staff had been very good, they were unable to accommodate the specific times during the day when support was needed and consequently they had stopped the care.

Routes Healthcare provided a rapid response to requests for support made by the health commissioners. The service could respond extremely quickly to meet urgent need. We saw, and were told by commissioners, that the service could deliver packages of care to support people at the end of their lives within two hours, and the area manager said that the time between a referral for end of life care to care delivery was approximately two to three hours. Staff were well trained in end of life care and the use and care of equipment such as tracheostomy care, oxygen and ventilators, and could provide immediate care to people who had been discharged from hospital on a fast track care pathway to die in their own home. Some staff had undergone training in palliative paediatric care, and could deliver end of life care to children. We were told that support could be provided for a few days only for people at the end of their life. When people were on this fast track, the service recognised the priority to get them home, and if there was insufficient time to visit them in hospital they would accept a temporary care plan provided by the Care Commissioner. Once they had returned home the service would complete their own person-centred plan to detail support and guidance for staff to follow.

We asked staff about the difficulties of working with clients receiving end of life care. One care worker explained that they remained professional at work but went for a walk to de-stress. They said, "We are only human, we are close to our clients. It breaks your heart, but helps us to appreciate what we've got. It's a spur, I want to shine in this job more and more". Staff told us that they were invited to funerals, and that they attend; the service were accommodating of their requests to attend funerals. The service also provided six bereavement counselling sessions to any staff who required this support.

One person whose relative was supported by Routes in their last months told us, "I couldn't fault the service. If I needed any changes to the care plan they amended it, and thought about my needs too" We saw thank you cards which read, for example, 'Thank you for the kindness and respect shown to mum and the family in her final weeks.' Another said, 'You entered [my relative's]' life as strangers, but left as friends,' and 'Everyone [at Routes] without exception showed great compassion.'

The service had a complaints procedure, which was available in the service user guide, intranet, and staff handbook. When we asked, people told us that they knew how to make a complaint if required. One person told us, ""I can phone them if I'm not happy, and will ring to let them know Other people we spoke to echoed this. One said, "I have a good relationship with the office, and they are accommodating and polite", but when asked other people we spoke with told us, "I've never had to complain. I trust them fully," and "I can't complain, I'm pleased I have got care from Routes." The service had a positive and transparent approach to complaints. Any complaints received were managed in line with the provider's complaints policy. We looked at the complaints file and saw that all complaints had been logged and gave clear explanations as to how the matter would be resolved.

Requires Improvement

Is the service well-led?

Our findings

It is a requirement under The Health and Social Care Act (2008) that the manager of a service like Routes Healthcare is registered with the Care Quality Commission. When we visited the service did not have a registered manager and was therefore not meeting the requirement. The previous manager had left in March 2017. The nominated individual told us that they had appointed a new manager who was due to start with the service in August 2018. In the interim, the area manager had taken responsibility for the management of the service and spent three to four days each week days on site working directly with the service in Rochdale. We asked the nominated individual why it had taken so long to appoint a new manager and were told that this was due to the difficulty in finding a person with the right managerial know-how and clinical knowledge and understanding of the complex needs of the people supported by Routes Healthcare, and previous recruitment drives had been unsuccessful. Both the area manager and the nominated individual were present on the days we were onsite during this inspection.

Overall governance was provided by Routes Healthcare Board who met on a regular basis. After each board meeting six key points were identified and filtered to all staff working for Routes. This ensured clarity of purpose, understanding of roles and maintained a consistent approach to learning. Messages were positive and aimed at improving the confidence of the staff, with a high emphasis on continuous improvement, as illustrated by the recent introduction of the Routes TV channel on YouTube.

In the absence of a registered manager the area manager was supported by a management team consisting of a deputy manager, six care coordinators and two clinical lead nurse assessors. Staff were also supported by Routes Healthcare 'Excellence in Care Team', who provided ongoing training and development opportunities and advice to staff working in the field.

All the people we spoke with were positive about the management team. One care worker told us, "Any problems you can approach any of them'. Another said, "Routes is a fantastic company to work for. They look out for the [people who use the service] and they look after us care staff too". People who used the service told us that they "Had a good relationship with the office" and the care coordinators had a visible presence and always made themselves available for contact, that they were pleasant, polite and knowledgeable. However, one person told us that they were not always able to accommodate their needs and wishes to provide care at a specified time in the day.

We saw that the management team had adopted an inclusive management style that empowered and supported staff. Regular supervision assisted personal growth and access to good and bespoke training increased staff confidence in their abilities. Staff understood their roles and responsibilities to work for the benefit of the people who use the service. We saw that staff rotas reflected stable staff teams with very low turnover, meaning that people worked well together. Staff confirmed that they were willing to cover any sickness or leave to provide continuity in support, so reliance on unfamiliar staff was minimised. This ensured continuity of care which was delivered by staff who were familiar with the people who used the service. Staff told us that there was good communication and support from the management team, and that they would regularly visit them at work.

Staff told us that they felt valued by Routes Healthcare. Prior to our inspection the service sent us a Provider Information Return (PIR) which stated, "We are rewarding carers for their fantastic work. We are introducing a hall of fame for carers who have done something amazing - this is voted by the staff themselves." We were informed that when a compliment was received about members of staff they sent out a thank-you postcard on the same day from the office. Carers told us that they had been 'blown away' by this. One care worker told us that they were always informed about any compliments received, and one said they were proud to have been awarded a certificate of inspiration for excellence in care and a £25 voucher. A Team leader we spoke with told us "I have a fantastic team. Some packages are really challenging, but they all work so hard!". An excellence in care award was presented on a quarterly basis rewarding staff with a certificate and voucher for going above and beyond what is expected of them. The nominated individual told us that the service was keen to promote good staff, but recognised that some care workers did not want to move into management, so other avenues for career progression had been explored. Ten staff had completed a 'train the trainers' course and worked as part of the training team, passing on knowledge and skills to new staff.

The service had a vision statement which was 'excellence in all we do'. To achieve this goal an 'Excellence in Care' team had been established. In addition to providing training support and advice they sought continuous improvement in service delivery. We looked at the most recent monthly newsletter produced by this team. It included updates on work, introductions to new starters and nominations for the excellence in care award. People who used the service were encouraged to comment on the support provided by individual carers, and positive comments were published. These included, 'All staff are really lovely', 'very happy, overwhelmed', and '[Named care worker] makes us the best porridge in the northern hemisphere.'

The service was committed to continuous improvement and had recently developed the 'Routes cause-consultation committee'. This included staff from field, hub and branches who meet bi-monthly, and sought the views of a cross section of stakeholders and employees to analyse and review service provision. We saw in the newsletter that this group was looking for employees who 'will challenge, speak up and be heard and be occasionally able to agree and disagree.'

Systems were in place to monitor the quality of the service to ensure people received safe and effective care. The nominated individual undertook a monthly visit and compiled a report for the Board and we were told that regular audits/checks were undertaken on all aspects of the running of the service. We looked at some of the audits that had been undertaken, such as a recent medicines audit. We were also shown an in-depth monitoring report that had been undertaken on all aspects of care and service delivery and a monthly compliance matrix which monitored performance of a number of key performance indicators. This focused on the management of staff to ensure regular supervisions observations, and quality of recording and record keeping. Action plans showed where improvements were needed and what action had been taken to date to address any identified issues. All identified actions had been completed within timescales.

The people we contacted about the service believed that they had been listened to. The service regularly sought feedback from staff, relatives and people who used the service with surveys sent out annually. We looked at the most recent service user survey conducted in early 2018, and comments were mostly positive, for example, one comment was that "[Routes] are more on the ball than health professionals, we have such a good rapport." Where negative comments were noted, there was evidence of follow up action, for example, where people commented on the time of visits, action was taken to reassure the person by telephone when their care staff were due to arrive.

The area manager told us that they viewed any complaints as an opportunity to gain feedback and to improve the service. Complaints were analysed monthly by the central office to identify any trends or areas for development. A six-monthly complaints review would identify any trends and area for development.

Routes Healthcare had developed good relationships with commissioners from health and social services. The commissioners we spoke with told us that the service provided a good and reliable service. The area manager told us that they regularly worked in partnership with district nurses, hospices and other healthcare professionals and this ensured that they remained up to date with recent knowledge and information about the delivery of safe care A representative from the service regularly attended the local safeguarding forum to gain local knowledge. We were told the service regularly liaised with Skills for Care on projects and attended seminars to learn and share good practice.

We checked our records before the inspection and saw that accidents and incidents that CQC needed to be informed about had been notified to us by the service. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.