

County Home Care Services Limited

Radis Community Care

(Gloucester)

Inspection report

Unit 4
The Steadings Business Centre, Maisemore
Gloucester
Gloucestershire
GL2 8EY

Tel: 01452305628

Date of inspection visit:
23 June 2016

Date of publication:
28 September 2016

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

This inspection took place on 23 June 2016 and was announced. Radis Community Care (Gloucester) provides domiciliary care services to people who live in their own home. At the time of our inspection there were 140 people with a variety of care needs, including people with physical disabilities and people living with dementia using the service. We spoke to people who received services from Radis in August 2016.

We last inspected in June 2013. At the June 2013 inspection we found that the provider was meeting all of the requirements of the regulations at that time.

At our inspection on 23 June 2016, there wasn't a registered manager in post. The previous registered manager had left the service in January 2016. An acting branch manager was in position and they were in the process of applying to be registered with the care quality commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People did not always have the information they needed and wanted regarding their care. People and their relatives told us they did not always know which staff were coming to provide their care and when.

People received safe and effective care which enabled them to live in their own homes. People and their relatives praised the care staff and spoke positively about the care they received. The care people received was personalised to their needs. People and their relatives felt involved in their care and spoke positively about the relationships they had with staff.

People told us they felt listened to and could not fault the care they received. People were cared for by care staff who were supported by the manager and provider. Staff had access to professional development through the provider. The manager and provider knew the needs of staff and had systems to ensure staff had access to the training and support they needed. All staff told us the manager and provider was supportive.

The manager and provider had systems to monitor the quality of service people received. The systems enabled the manager and provider to identify concerns and drive improvements the actions they had taken

to improve the service had not always been recorded. The manager did not always use the information provided to them about staff call times to identify any trends or concerns.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe. People felt safe when receiving care from care staff. Staff had a clear understanding of their responsibilities to identify and report concerns or allegations of abuse.

People told us care staff spent time with them. Staff told us they had enough time to assist people in a safe way; however sickness had an impact on their time. The provider ensured staff were of good character before they supported people.

Risks to people's care had been identified and there was clear guidance to staff on how to manage these risks. Where people needed assistance with medicines, this was done in a safe manner.

Is the service effective?

Good ●

The service was effective. Care staff had access to effective professional development. They received one to one meetings with their line managers and felt supported.

Where necessary, people were supported with their dietary and healthcare needs. Staff followed the instructions provided by healthcare professionals.

Care staff had knowledge of the Mental Capacity Act, and people's rights were being protected.

Is the service caring?

Good ●

The service was caring. People and their relatives spoke highly about the care staff and felt they were treated with dignity and respect.

There was a caring culture. Staff spoke about people in a kind and a caring manner.

Is the service responsive?

Good ●

The service was responsive. People's care plans were personalised to people or their needs.

People and their relatives were involved in the planning of their care.

People and their relatives were confident their comments and concerns were listened to and acted upon by the provider.

Is the service well-led?

The service was not always well well-led. People and their relatives did not always receive the information they needed.

The provider carried out audits and had systems in place which enabled them to identify concerns; however there was not always a clear record of the action they had taken and monitoring systems were not always utilised effectively.

The views of people and their relatives were regularly sought. Staff told us they could raise ideas and were involved with decisions made within the home.

Requires Improvement ●

Radis Community Care (Gloucester)

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 was 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 23 June 2016 and was announced. We gave the provider 48 hours' notice of our inspection. We did this because the provider or manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that they would be in. The inspection was carried out by one inspector.

We reviewed the information we held about the service. The previous registered manager had completed a Provider Information Return for this service. 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 took this into account when we inspected the service. We reviewed the notifications about important events which the service is required to send us by law and also spoke with a local authority commissioners and healthcare professionals including social workers about the service.

We spoke with 15 people who were using the service and six people's relatives in August 2016. We spoke with 10 staff which included seven care staff, a care co-ordinator, the branch manager and a regional manager. We also spoke with the provider of the service. We reviewed 12 people's care files, staff training and recruitment records and records relating to the general management of the service.



Our findings

People told us they felt safe when receiving support from care staff. Comments included; "I'm safe with a member of staff"; "They make me feel safe"; "Very safe"; "Yeah I feel safe with them" and "They make you safe."

People were protected from the risk of abuse. Care staff had knowledge of types of abuse, signs of possible abuse which included neglect, and understood their responsibility to report any concerns promptly. Staff told us they would document concerns and report them to the care coordinator, manager or the provider. One staff member said, "I would ring the manager or on call. There is always someone at the end of the phone." Another staff member added that, if they were unhappy with the manager's or provider's response they would speak to the local authority safeguarding team or CQC. They said, "I can go to safeguarding. I've done that twice." If staff felt someone was at immediate risk of harm or abuse, they told us they would take immediate action. For example, one staff member told us, "I would contact the police if the person was in immediate danger."

The manager and previous registered manager raised and responded to any safeguarding concerns in accordance with local authority safeguarding procedures. Since our last inspection the service had ensured all concerns were reported to local authority safeguarding and CQC.

People's care plans contained assessments of all aspects of their support needs. Assessments included moving and handling, nutrition and hydration and medicines. People's risks had been identified, assessed and documented. Care staff had clear guidance on how to protect people from their individual risks. For example, one person needed the support from two care staff and equipment to enable them to safely mobilise. Care staff had clear guidance on how to assist this person and the risks to the person and their own health if this guidance wasn't followed. Another person had a clear risk assessment on the support they needed from care staff to protect them from the risk of eating food which was no longer fit for purpose.

Care co-ordinators and senior care staff carried out risk assessments on the environment where people received their care in. These assessments ensured the risks to people and staff were identified and discussed. such as keeping pets in different rooms, and removing furniture or items which could pose risk were removed.

People and their relatives told us when staff arrived they spent the time they expected with them. Comments included: "They stay, we can have a chat, they always leave me comfortable"; "They have a chat

with me, we put the world to rights, I can't grumble"; "They will sit and talk to me if I'm not okay" and "They never seem rushed."

People and their relatives told us they were often informed if staff were running late. Comments included: "When they have an emergency they do their best to let me know"; "They tell me what's going on" and "They let us know if they're going to be very late. Emergencies happen."

Staff told us they were given enough time to travel, however some staff told us their working shifts were affected by sickness, particularly at weekends. Comments included: "It's getting better. Nine times out of ten you get travelling time"; "Weekends are bad for sickness, we copy, people get their calls late" and "We generally do have enough time to care and travel. We can plan our time." The manager and a regional manager were aware of these concerns and recruitment for new staff was on-going.

Records relating to the recruitment of new care staff showed relevant checks had been completed before staff worked unsupervised working in people's homes. These included employment references and disclosure and barring checks (criminal record checks) to ensure staff were of good character.

People and their relatives told us staff assisted them with their prescribed medicines. One person told us, "They help me with my medicines; they watch me take my medicines, with clear instructions." Staff told us they had the training they needed to provide people's medicines. One member of staff told us, "People have dossett boxes. We prompt them. We give them the information they need." People's medicine administration records were completely consistently and no concerns were raised regarding the administration of medicines.



Our findings

People and their relatives were positive about care staff and felt they were skilled to meet their needs. Comments included: "The staff are very well trained"; "They know what they need to do"; "They're all very good and well trained. They know what to do and how to do things" and "They seem well trained and some are really exceptional." One person spoke positively about the care they received, and how staff respected them and their relative who was living with dementia. They told us, "They are very good with dementia. They never cause upset. They're very well trained and you can tell they're trained."

People's needs were met by care staff who had access to the training they required. Care staff told us about the training they received. Comments included: "Yes I have the training I need"; "The training is really good" and "I think we have the training we need. We can request training, I asked for training around multiple sclerosis, which they are looking at." Staff were supported to undertake additional training as required, for example when people's needs changed. One staff member said, "If there is anything extra I need, I can ask. I asked dementia training which I got. I also asked for stoma care training, they arranged this training." The member of staff told us this helped them improve the level of care and support they provided people. They said, "It gives us confidence, makes service users relaxed. We always look for what's not right."

New staff were given time, support and training to meet people's needs. One staff member spoke positively about the support they had during their induction to the service and the support they received working towards a national vocational qualification (NVQ) in health and social care. They told us, "I am in the middle of health and social care level two qualification. I have a mentor. I get the support I need and I can ring to get support. The management are all good, always at the end of the phone." The manager told us that care staff were being supported to complete the care certificate as part of their training. The care certificate training allowed the manager and provider to monitor staff competences against expected standards of care.

People received care from care staff who were supported and had access to frequent one to one meetings with their line managers (one to one meetings discussed care staff needs, such as training and support as well as any concerns). Care staff spoke positively about one to one meetings and felt they were supported. Comments included: "They are quite useful. Any worries and issues we discuss and it works at well" and "It's a chance to talk about things, any concerns and any suggestions we may have".

Staff we spoke with had undertaken training on the Mental Capacity Act (MCA) 2005. 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. Care staff showed a good understanding of this legislation and were able to explain specific points about it. Comments included: "I encourage people. Where people can make decisions we are aware and we give them time to make them"; "We never force, we encourage and prompt" and "We try and keep consistency of staff for people living with dementia (who may need support to make decisions) this builds familiarity and enables us to support them with their choices and care." People's care plans contained mental capacity assessments which clearly detailed where people could or could not consent to their care and other healthcare professionals involved in their care. For example one person did not have the capacity to consent to their care, however their power of attorney (a power of attorney has been authorised to make decisions on the persons behalf around their finances and affairs and/or health and wellbeing) had provided this consent.

People told us they were in control of their care and that they never felt forced to do something they did not want to do. Comments included: "They always involve me, they never do anything I don't want them to do" and "They explain things and they always leave me comfortable. It's nice, I never worry about them."

People spoke positively about the food and drink care staff provided them. One person who was assisted with their dietary needs told us, "They know what I like to eat and the support I need." Another person told us, "They know about my diabetes, I'm happy."

People's care records documented the support they needed with their nutritional requirements. For example one person required support, prompting and encouragement to meet their nutritional needs and protect them from their risks of malnutrition and dehydration. Care staff were aware of these needs and spoke confidently about how they assisted them. One member of staff told us, "Nutrition is a concern; we encourage them to eat and drink."

People were supported to maintain good health through access to a range of health professionals. These professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. These included GPs, social workers, community nurses and occupational therapists. Where guidance had been received regarding people's care, this was documented as part of the person's care plans. For example, care staff worked with one person's GP and other healthcare professionals to protect the person from self-neglect and to promote their independence. People and their relatives spoke positively about care staffs ability to identify changes in their wellbeing and take action. One person told us, "The support is great. They will ring doctor if I need. To me they're very supportive."



Our findings

People and their relatives spoke positively about the care they received and the care staff supporting them. Comments included: "Yes, I like them, usually pretty good", "I get on well with all of them, they are very friendly", "The carers are exceptionally polite, you can ask them to do anything", "We've always had very good people (staff). We're very happy with them" and "They're very good. One is extremely good, they are excellent."

Care staff spoke with kindness and respect when speaking about people. Care staff clearly knew people well, including people's personal histories and what was important to them. Care staff enjoyed their job and were enthusiastic about providing good quality care. Comments included: "We get to know people and what's important to them, we can then provide clear care and work with people" and "I treat people like family. We always try and provide continuity."

Care staff told us how they provided positive person centred care. For example, one member of staff told us how they assisted one person to ensure their day to day needs were met. They said, "They don't like to be rushed as they are blind. You really have to take your time, explain things and give them encouragement."

People and their relatives told us they were treated with dignity and respect by care staff. Comments included: "They treat me with dignity and respect", "They are very polite and respectful"; "They are always polite and respectful. Ensure the care is given in private" and "They make me feel comfortable, never rush me or make feel exposed."

People told us they felt comfortable with care staff. One person told us about their initial anxieties about receiving care from Radis and how care staff had helped to reduce these anxieties. They told us, "I dreaded it, but it's turned out well, they made it very good I get regular carers and they treat me very well. I can't grumble".

Care staff told us the importance of respecting people's dignity. One staff member told us, "When I'm running late I let people know, if they don't know it can make them anxious." Another care worker said, "One person likes to look their best. We help with shaving and their appearance. This is really important to them."

People spoke positively about the caring relationships they had made with staff. Comments included: "I've had one girl who is really good. They really know what to do"; "One carer was invaluable. We usually get the same carer, which is good for us" and "I usually have the same staff, they know me and we can have a good

natter." Staff spoke positively about providing continuity of care, particularly for people living with dementia. One staff member told us how they linked and worked with another staff member to ensure the person received continuity of care. They spoke positively about how this enabled them to identify changes in the person's wellbeing.



Our findings

People were involved in decisions about their care. Thorough assessments were carried out with people when they started using the service. Assessments included; communication, mobility, social care needs and medicines. For example, one person's assessment provided guidance of how they should be supported with their mobility to ensure their health needs were maintained. A care co-ordinator spoke positively about how they involved people in the assessment of their needs. They told us, "We get people to talk about themselves, find all the little things they like to do, we build a picture. We want to know people's needs to get a clear picture of that person; we make a special and tailored care and care plan for them."

Assessments were used to develop detailed care plans that identified people's needs and their personal support requirements. For example, one person's care plan documented how they liked a clear routine of care, which included aspects of their care needs such as personal hygiene and moving and handling. Clear guidance was provided to staff to ensure they had the information they needed to meet the persons' needs.

People's care plans contained information relating to specific conditions and how their conditions should be supported. This included people living with dementia and people with diabetes. Care plans were personalised and included details of people's needs and what was important to them. For example one person's care plan contained clear information about the support the person required to manage their diagnosis of diabetes and the support they received from other healthcare professionals.

People's relatives and Power of Attorneys (PoA) were involved in people's care. A PoA is a relative or significant other who has been given the authorisation to make decisions regarding aspects of people's lives, such as health and wellbeing and/or finances and affairs. For example, one person's had been involved in all decisions and had assisted to develop the person's care plan. They spoke positively about the support they and the person received from Radis. They said, "The staff involve me, they talk to me before they give care."

People told us the manager and care staff were responsive to any changes in people's needs. One person told us the service were very responsive. They said, "I know I can phone them (when I'm) straight out of hospital. They are very flexible, will accommodate me, and stay with me. I wouldn't want to change or lose them."

The manager and care staff were responsive to people's needs and looked at ways to improve people's lives. People and their relatives spoke positively about care staffs ability to identify changes in their wellbeing and

take action. One person told us, "The support is great. They will ring doctor if I need. To me they're very supportive."

People and their relatives told us they knew how to make a complaint and had a copy of the service's complaints policy and information regarding complaints. Everyone spoke confidently about raising their concerns, and felt they were listened to. Comments included: "I have no complaints. I know I can call if I need to", "I can ring Maisemore (location of office), always been helpful. I can't grumble" and "I've never had to contact the office, however I know I can, anytime."

The manager had a log of compliments and concerns they had received prior to the inspection. Where concerns had been raised, the manager had used this information to improve the service. For example, one complaint was raised regarding communication. This concern had been acted on, and staff had supervisions to discuss these concerns and use them to improve.



Our findings

People did not always receive the information they needed regarding their care. People and their relatives told us they did not always know when staff were visiting them, or which member of staff were planning to visit. Comments included: "I used to have a rota. It doesn't affect me very much, but we like to know"; "I'm not sure what time they're coming. It gets me het up. It makes me feel anxious"; "I haven't got a clue who is coming. We used to have rotas, now we don't always have them"; "Never know what time they're coming. I'm a bit in the air" and "We would like the rota's back." We discussed this concern with the manager. They informed us they were aware of this concern and were starting to send rotas out to people. They had identified which people were more vulnerable and needed the rotas as a priority. They planned for everyone to start receiving a rota every week from September 2016.

The provider and manager had a range of systems to monitor the quality of the service they provided. However not all of these systems were being used effectively. For example the provider had an electronic call monitoring system (a system which enables care staff to show when they had arrived and left people's homes on time). This system provided the manager clear information about the staff calls times. However they were not using this information to monitor the quality of the service. We discussed this with the manager who informed us they were planning to use this information to identify concerns and to make necessary improvements.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sought people's feedback about the service. People and their relative's views were listened to and where concerns or suggestions had been identified, an action was implemented. These actions informed the service development plan. For example, the results of the 2015 survey, found that not all people who received the service felt they had been involved in their care planning or knew how to make a complaint about the service. These actions were included in the service development plan. People we spoke with felt changes had been made and they now knew how to make a complaint if required. However, actions the provider and manager had taken were not always clearly documented on the service development plan.

However, the service development plan provided clear actions in relation to people's care plans, staff training and staff recruitment. Where shortfalls had been identified, clear and specific actions were in place. The manager and regional manager informed us they were in the process of reviewing the service

development plan to ensure it was still effective in driving improvement within the service.

Annual quality audits were completed by the service. These audits were completed by quality audit staff from Radis Community Care. They identified actions which needed to be taken and how the service needed to improve. During the 2015 audit they identified that risk assessments were not always detailed and required more information to enable staff to manage people's individual risks. An improvement plan had been implemented which provided specific actions the branch needed to achieve. These actions informed the service development plan. People's care plans provided clear information around risks and the support people needed.

The provider sent staff a newsletter which provided them with information. A recent newsletter in June 2016, discussed issues such as communication, the media and the national living wage. It gave staff clear contact details to raise concerns and issues if people needed.

People and their relatives spoke very positively about the manager. Comments included: "(The name of the manager) is very approachable" and "I would go to (the name of the manager) they are very good." One person spoke positively about the management and that they had filled in a form about the service and felt the service was good.

Care staff felt the provider was supportive and approachable. Staff felt confident that they could suggest ideas to the manager and provider and that these ideas would be listened to. There were regular staff meetings, where staff could communicate ideas and ensure important messages were circulated to all care staff.

People were protected from risk as the provider ensured lessons were learnt from any incident and accidents to protect them from further harm. They used this information to identify any trends around accidents and incidents.

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People did not always have the information they needed regarding their care. Quality Assurance Systems were not always effectively used. Regulation 17 (2)(d)(ii).