G P Homecare Limited

Radis Community Care (Reading)

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 15 July 2016. We gave the registered manager short notice as we needed to be sure she would be there to assist us with the inspection. The service required improvement in a number of areas at our last inspection in January 2015 although no breaches of regulations were raised.

Radis Community Care (Reading) is a domiciliary care agency that provides personal care and other support to 101 people in their own homes. The service is operated by GP Homecare Limited.

The service had a registered manager as required to manage its day to day operation. 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 and relatives felt staff were caring and kind and worked in ways that supported people's dignity and privacy. They felt staff involved them in their care and encouraged them to do what they could for themselves. People told us staff asked how they liked things done and respected their wishes. People felt consulted about their care needs which were regularly reviewed.

Complaints were responded to and addressed appropriately by the registered manager and records described the action taken to resolve them. The views of people and their relatives about the agency's operation had been sought by means of a detailed survey. The feedback was mostly positive and where issues had been raised they were included in an action plan and addressed.

Medicines recording and management systems had improved since the previous inspection to reduce the risk of potential errors. However further work was needed to ensure that all staff had their competency assessed periodically with regard to medicines management and also moving and handling.

Staff knew how to keep people safe and were aware of the signs of possible abuse and how to report it. They felt the registered manager would respond appropriately to any concerns raised.

Where others gave consent on behalf of people who received support, it was not always clear they had the legal authority to do so. This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Consent). This meant people's rights might not always be safeguarded.

Staff training had improved and there was a rolling programme of induction and training to ensure staff remained up to date with their skills and knowledge. However, there was a need to improve the induction process. This was reported to be about to be addressed by the adoption of the Care Certificate induction process.

The level of detail in risk assessments had been improved. People were safer because these documents included information for staff on how to address identified risks. The level of detail in care plans had also improved and they provided the information staff needed to provide people's care in a person-centred way, respecting their wishes.

A robust staff recruitment process helped ensure that staff had the necessary skills and approach to care for vulnerable people. People usually received support from a regular team of staff who mostly arrived on or around the time they were due and provided the required care according to people's wishes and their care plan. People's consent was sought with regard to the day to day care support provided.

Staff received regular support through supervision meetings and annual appraisals; and were kept in touch with changes and other information via regular newsletters. However, team meetings were infrequent, so opportunities to discuss care practice with colleagues were limited.

The service had an overall development plan which identified goals and how they would be measured. However, the views of the staff team had not been sought recently to monitor morale and identify any concerns.

Management monitoring systems had improved. However, it was not always possible to see evidence of the monitoring that had taken place.

We have made a recommendation the registered manager refers to relevant national guidance to enable her to demonstrate a more systematic approach to the monitoring of records, events and the completion of cyclical tasks.

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.

Medicines management had been improved. However, additional competency checks were needed to ensure all staff were regularly assessed as competent to administer medicines and also with regard to manual handling.

Risk assessments had been improved and identified the action necessary to address identified risks.

Staff knew how to keep people safe and how to report any concerns to management and felt these would be taken seriously and acted upon.

A robust recruitment process was used to ensure staff appointed had appropriate attitudes and skills.

Is the service effective?

Requires Improvement

The service was not always effective.

It was not always clear, where others had given consent on behalf of people, that they had the legal authority to do so.

Further improvements to staff induction were necessary through the introduction of the Care Certificate or equivalent process.

Improvements to staff training had taken place and the need for staff training updates had been identified and these courses scheduled.

People usually received care and support from a regular team of staff who they knew and who knew their needs. Where new staff were assigned, they were usually, but not always, introduced in advance.

Staff received regular support through one to one supervision meetings and annual appraisals. Regular newsletters were sent to staff to update them on relevant information and changes. However, team meetings were not held very regularly.

Is the service caring?

Good

The service was caring.

People felt well cared for and told us staff were kind and caring.

People's dignity and privacy were supported by staff in the course of providing their support.

Staff or the office usually, but not always, contacted people to let them know if staff were running late.

Is the service responsive?

Good

The service was responsive

Care plans had been improved further and contained enough detail to enable staff to deliver care and support in a person-centred way.

People and relatives were involved in reviewing their care needs and care planning.

Complaints had been responded to and addressed by the service.

Is the service well-led?

Good

The service was well led.

Systems for monitoring the service had improved. However, we recommended the registered manager established a more effective way to demonstrate that appropriate regular monitoring of records and events took place.

Surveys of people's views had taken place and actions taken to address the points raised. The views of staff employed by the service had not recently been sought.

A development plan was in place for the service which identified the priorities for the coming 12 months and when actions were taken.

Radis Community Care (Reading)

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.

We last inspected the service on 20and 21 January 2015. At that inspection the service was rated "Requires improvement" overall, although no breaches were recorded.

This inspection took place on 15 July 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that the manager would be available. The inspection was carried out by one inspector.

Before the inspection, the provider completed 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 looked at the information provided in the PIR and used this to help us plan the inspection. Prior to the inspection we reviewed the records we held about the service, including the previous inspection report, details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

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We sent pre-inspection surveys to 50 people who use the service, receiving 20 completed replies. We also surveyed 29 staff, of whom seven replied, 50 relatives, of whom three replied and four community professionals of whom one replied. We further telephoned seven people who were receiving a service, two relatives of people using the service and eight staff, to obtain their feedback about the service.

During the inspection we spoke with the area manager and the registered manager. Prior to the inspection we contacted seven representatives of the placing local authority and healthcare professionals to seek their views. We received no feedback or concerns about the service.

We reviewed the care plans and associated records for eight people, including their risk assessments and reviews. We examined a sample of other records to do with the service's operation including staff records, surveys, meeting minutes and monitoring and audit tools. We looked at the recruitment records for six of the more recently recruited staff.

Good

Is the service safe?

Our findings

When we inspected the service last in January 2015 we found although people felt safe, the service needed to make further improvements to risk assessments and competency checks of staff skills, to minimise the risk of harm. We had also identified a potential risk due to the practice of hand-transcribing medicine administration instructions onto medicines administration record sheets.

When we carried out this inspection in July 2016 we found that risk assessments had been further improved and now provided sufficient information for staff to enable them to minimise identified risks to people. Risk assessments had been signed by the person supported or their representative. They included an assessment of any risk presented by the person's home environment or needs and an action plan in the event of fire. For example, one person's risk assessment addressed the risk presented by their front steps, which became slippery when wet. Another gave instructions for staff on manual handling aspects when supporting the person. Risk assessments were also in place to address issues identified for particular staff, for example around chronic conditions or injuries which could impact on their work. The registered manager had begun completing these as part of the annual appraisal process.

Medicines administration record sheets had recently been improved because administration instructions were now typed on them. The pattern of administration times had been made visually clearer by shading out times when a medicine was not due to be given. The medicines management system was robust and staff received training before being allowed to administer.

However, insufficient progress had been made on staff competency checks and not all staff had yet had recorded competency assessments in key areas relating to safety, such as medicines management and manual handling. The area manager told us that the imminent roll-out of the Care Certificate induction process would address this for new staff. However, the provider needed to decide how to ensure existing staff attained at least the same level of competence and had this checked and recorded.

People and their relatives felt people were safe when being supported by the service. One person said, "… safe, yes definitely, they treat me well" and others said' "I feel safe" and "I feel safe with them." A relative told us their family member was, "…safe in their care" and another said, "He feels safe."

Staff had completed safeguarding training and most knew how to keep people safe and how to report any concerns they might have. One staff member seemed unsure about reporting procedures but all felt management would treat any concern they raised seriously and take appropriate action.

Staff told us that the rate of turnover of staff had been an issue in the past but that new staff seemed to be recruited continually to fill vacant posts. Some felt the most recent pay rise had helped with recruitment and retention.

The registered manager felt that recruitment had not been a problem recently. She said they always offered exit interviews for staff to understand their reasons for leaving although not all staff took up the opportunity

to attend. The service had not needed to use any staff from other agencies to cover care calls in the previous 12 months. The service had attended recruitment fairs as well as linking with local colleges and schools to recruit new staff.

Staff recruitment files contained the required evidence and demonstrated a robust process of pre-employment checks. These included checks of any previous criminal record, references and evidence to confirm the person's identity and their right to work in the UK. Applicants completed an application form and a health questionnaire and provided a history of their previous employment. One person's application form indicated gaps in their employment history. The registered manger agreed to seek information about these and record it in their file. Appropriate action had been taken by the provider where staff had not performed satisfactorily.

Requires Improvement

Is the service effective?

Our findings

When we inspected the service last in January 2015 we found although the service was generally effective, improvements were still needed in some areas. There was a need for better recording of people's consent to their care. Evidence of the legal authority for others to consent was needed, together with confirmation regarding the person's lack of mental capacity, where this was the reason for consent being given by others. We also found that not all staff were up to date with the necessary core training to ensure their knowledge and skills remained current.

When we carried out this inspection in July 2016 we found further progress had been made with training. There was a rolling programme of training in place. The service had a person responsible for managing the staff training who was himself trained to deliver manual handling and safeguarding training to the staff. The registered manager told us it was planned that he would also be trained to enable him to deliver training in other areas.

A training notice board in the office identified the individuals with training refreshers due and where courses had been booked. It identified regular fortnightly scheduled induction sessions and upcoming training sessions on safeguarding, manual handling and recording and reporting. The service had previously used a lot of computer-based courses but the registered manager told us they planned to deliver more training through face-to-face courses.

Staff received an induction, led by the in-house trainer, which included the core training necessary for their role. Although the service's training record included a column for completion of the nationally recognised Care Certificate induction, the service had yet to commence this for any staff. The area manager told us the service was about to commence the Care Certificate for the latest recruits.

Staff told us they received regular training updates and had been observed delivering care during spot check visits by senior staff. Some had also worked alongside senior staff, including the registered manager. We saw records of spot checks having taken place to observe staff practice.

People's records, care plans and risk assessments noted whether the person themselves, or a representative had consented, and were signed by them. However, where documents or consent had been signed by someone other than the person themselves, it was still not clear they had the legal authority to do so. The registered manager reported in her pre-inspection information return that none had given Power of Attorney (POA) to others and only one person had a court-appointed deputy appointed to make decisions on their behalf. Three of the files we saw included consent signed by people other than the care recipient. In two cases the relevant section of the care plan regarding legal authority and capacity, was not completed and no copies of such authority were on file. In one of these instances the registered manager told us the person was physically unable to sign for themselves. However, this was not documented, nor was there a record confirming they had verbally consented to the plan. The registered manager told us all of the people currently supported had capacity to consent to their care. Another person's file noted they were unable to sign but in this case the POA section noted the person made their own choices and decisions with the help

of their wife although there was no legal confirmation.

Staff told us people could mostly give day-to-day consent to their care and they always asked. However, at times they may ask the person's partner for consent. In such situations the person's right to make their own decisions and give consent to care may not always be respected. People and relatives told us staff sought consent from people or their representatives before providing their care.

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.

In the examples above, there was no evidence of capacity assessment, nor of an appropriate best interests discussion, to indicate people's right had been protected, where others had consented on their behalf. Capacity for decision-making must always be assumed unless there is an assessment indicating the contrary.

This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were happy that staff were competent and met their needs. One described staff as, "…very friendly and caring, and we have a good laugh as well", and added, "I feel comfortable with them." Another person said, "They know my routine, they know how I want things done, we have a laugh, it's like they are friends." One person said the service was, "…better than their previous agency" and added they were, "…very satisfied."

Staff told us that most of the time they supported regular people whose needs they were familiar with and who knew them. If they supported people new to them, they were usually, but not always, introduced to them and had the chance to read their care plan before providing support. Staff felt that their ability to arrive in a timely fashion to provide people's support had improved. The registered manager told us staff were now paid for travel time between calls. There seemed to be some confusion about this amongst the staff we spoke with, some of whom felt this was not always the case. Timeliness had been more effectively monitored now the call monitoring system had been extended across all of the areas covered by the service. This meant office staff were more readily aware of significant late running or where calls might be missed and could provide alternative staff where necessary. This system relied on a suitable phone being available. Where this was not available the person and staff member signed a record of the call times where possible.

People told us most of the time they were supported by a regular group of staff, but there were new staff at times, to cover holidays or sickness or turnover. People felt the consistency of staff had improved recently. One person said they had "…one regular carer most times and she's wonderful." People were happy that staff usually arrived on time. People said staff or the office usually contacted them if staff were running late, although they were not always called in this way. People mostly understood this was sometimes inevitable and were happy if they were kept informed. Two people told us about missed calls in the past and said the service had acted to address this and sent another staff member. They said this had not happened recently.

People said staff who were new to them were usually, but not always, introduced to them before starting to provide their care. They described how new staff would 'shadow' existing staff who knew them to, "...learn the ropes." We were told staff stayed for the required time, sometimes longer and completed the support

required. One person told us, "My needs are met" and said they had felt comfortable with the staff within a week. Another said they were, "…happy with the agency."

Staff felt supported by the management team. They told us they could call the office at any time and there was an effective out-of-hours on-call system should they need advice or support outside office hours. One gave an example where they had needed to seek emergency medical support for someone and told us, "… the on-call came immediately." Staff had received regular ongoing support through supervision meetings and annual development appraisals. Supervision was provided at least three-monthly and we saw records confirming the process.

Where staff were responsible for preparing meals as part of care visits they offered people a choice based on the available options. Support for some people included shopping and where staff did this they would shop based on the person's own shopping list. One person told us, "They do my breakfast and tea and do it well." Staff monitored people's health and wellbeing and would discuss calling the doctor if they felt the person was unwell. One person said, "They keep an eye on me and know if I'm not myself."

Good

Is the service caring?

Our findings

When we inspected the service last in January 2015 we found people felt staff were caring and supportive to them and treated them with dignity and respect.

When we carried out this inspection in July 2016 people told us they felt well cared for and were treated respectfully. People's comments about staff included, "...they are competent, very friendly and caring", "…they involve me if I feel like it" and "…they are very caring people." People praised the approach of particular staff and were happy that for the most part, care was provided by staff with whom they were familiar. Only one of the 20 respondents to our pre-inspection survey reported not having been introduced to a staff member before they provided their support. Two of the three relatives who responded also identified this as an issue. All 20 respondents were happy with the support and felt staff were kind and caring as did the three relatives who responded.

A relative said, "They treat [name] well" and described staff as "…pretty good, very friendly and helpful…. they are very happy to be flexible." Another relative said the staff were, "…good as gold" and treated their family member well.

Staff told us they respected people through seeking their consent and ensuring that personal care was carried out in private to safeguard people's dignity. Staff explained they took people to their bedroom or the bathroom, closed curtains or blinds and made sure they kept them covered up as much as possible. One staff explained that where two staff were present for some aspects of care, one would leave the vicinity when both were not required, to maximise the person's dignity. One staff member described the care provided as, "…second to none" and said people were, "…well looked after."

People's files included information on their interests and any cultural or spiritual needs to enable staff to respect these and engage effectively with people. Files also informed staff how individuals liked things done and areas of self-care or that offered by family members, so they could respect this in their work. Staff told us they usually had the opportunity to read this information in advance and shadow colleagues who knew the person, to get to know their day-to-day wishes.

People were happy staff helped to maintain their dignity. One person said, "They look after my dignity and are gentle and patient." A relative told us, "…they look out for his dignity, I can't fault them."

Good

Is the service responsive?

Our findings

When we inspected the service last in January 2015 we found further improvements were required in relation to the care plans. Care plans, although they had improved since our last visit, still sometimes lacked sufficient detail to ensure personalised care and were sometimes still too task-focused.

When we carried out this inspection in July 2016 we found the care plans had further improved. They contained relevant individual detail to enable staff to work in a more person-centred way and to respond to individual wishes and preferences.

People and their relatives told us they had been involved in planning people's care and that the person's needs were reviewed regularly. One person said they were, "…involved, definitely and [care plans were] reviewed every six months." Others also confirmed their involvement.

Relatives also confirmed they had been involved in reviews of their family member's care plan where the person wanted this. One said, "They involve me too."

Records confirmed the involvement of people and their relatives in reviews of people's care needs and the resulting care plans reflected their individual wishes and preferences. Reviews of people's needs took place regularly so care plans reflected the current position.

Staff described how they offered people choices as part of supporting them, in terms of things such as their preferred clothes and meals. They told us they always asked people their preferences. One gave the example of helping a person create a food shopping list of the items they wanted, then fulfilling this for them, to facilitate their choice of meals.

The complaints procedure was detailed in the service user guide which was explained to people as part of their care planning meeting. Four people said they had "…not had to complain." Another person said, "You can contact the manager," but had not needed to. One described her experience as one of, "Complete satisfaction" and another said, "I've got nothing to complain about." Several people said they had met or spoken to the manager and felt she was readily available to them. Feedback from our pre-inspection survey showed that over 90% of respondents knew how to complain if they were unhappy and were happy with the response of the service when they had raised an issue.

A relative told us they had not had any complaints recently. They had complained about something in the past and said this had been resolved at the time.

Six complaints had been recorded in the complaint log in the last 12 months. Records showed how the service had addressed and resolved each one and taken steps to reduce the risk of recurrence where appropriate. The steps taken had included financial recompense in one case, appropriate changes of staff and an instance of disciplinary action. As the result of action taken in response to complaints about timekeeping, the monitoring system had been extended across all areas of the service, resulting in improved

timeliness of calls. However, our survey suggested there was still room for improvement as 26% of respondents were still concerned about this.

Good

Is the service well-led?

Our findings

When we inspected the service last in January 2015 we found they had not applied their internal monitoring processes consistently, and identified issues had not always been addressed. The views of staff about the service had not been sought. The service had experienced a period without a registered manager and the recently appointed manager at the time had applied to become the registered manager. The then manager planned to introduce a monthly audit process and organisational audits were scheduled to monitor improvements. A survey of the views of people about their care had been carried out but no feedback had been given to people about the results or the actions proposed in response.

When we carried out this inspection in July 2016 we found that the manager in post previously had become registered and remained in post. Most people remembered having been asked their views about the service via surveys from the provider, which had taken place in 2015 and recently in 2016. Feedback was generally positive. The action plan arising from the 2015 survey showed how the service addressed identified issues and when they had been addressed. For example the service user guide had been revised and sent out again in response to comments from some people. Staff had also been formally reminded to notify the office if they were running late for calls.

The registered manager had ensured spot checks of staff had taken place, which was confirmed by the people and staff we spoke with. The survey results for the May 2016 survey, sent to 90 people were provided immediately following the inspection. Thirty six responses were received and feedback was positive. An appropriate action plan had been devised to address issues that were identified. For example, for the manager to meet with people who had indicated the wish to do so in their survey response, to discuss their needs.

The call monitoring system was now used across all areas, which had improved the effectiveness of the process. The registered manager provided a weekly business audit report to the provider via the computerised system. However, these audits had a largely business and process focus rather than referring to records or other issues within the branch. The registered manager carried out a range or audit checks of care files, and staff records. Although the process was not centrally documented to demonstrate the cycle, individual audit forms within people's files showed which records were checked. Following an internal audit in February 2016, an overall service action plan and a service development plan were in place, which identified the targets for the next 12 months and how they would be measured.

The registered manager had carried out some telephone satisfaction survey calls to people to obtain their views about the agency's performance. Again, there was no systematic plan scheduling these throughout the year, but monitoring calls were recorded within people's files when they had taken place. Some people appeared to have last received such a call in 2014, so it was not clear the system ensured everyone's views were regularly sought. The manager received three-monthly supervision from the area manager but was not required to produce a written report of her interim monitoring to demonstrate the process.

Staff told us that staff meetings had taken place although they were not very frequent. Records showed

there had been three team meetings in 2015, each attended by only six staff. They told us the office issued a regular weekly newsletter to keep them informed about events, changes and training. The provider also sent seasonal newsletters with company updates. Staff felt that monitoring of missed calls and timeliness had improved now that the monitoring system had been extended across all areas. They found the office staff mostly positive and supportive and felt the service was developing and improving. One said the service was well led and there were no problems with the manager, who they said had "…always been there to help." Staff felt supported through regular one to one supervision meetings and annual appraisals.

People told us the registered manager was; "approachable" and some had met her through assessment or review meetings, or when she had herself carried out care calls. One person described it as a, "well run service"; others said it had, "…improved with the new manager" and "…they have been very good since the change of manager."

Staff had mixed feelings about whether the service placed clear expectations on them. Some felt these were clear and were stated in the employee handbook and reinforced through the regular newsletters. Others felt the expectations on them were not always reinforced or made sufficiently explicit thereafter. They felt team spirit was alright although management did not always listen to issues raised by the staff. They confirmed that senior staff carried out random 'spot-checks' to monitor staff performance and behaviours. Several staff described the manager as, "Supportive" although one felt that the management in general, put a lot of pressure on staff, for example, to pick up additional calls. The views of staff had not been sought in a systematic way, for example by means of a recent survey.

The policy and procedures reflected a person-centred and individualised approach to providing care and support. For example referring to consulting, involving and asking people who were being supported, and enabling them to do as much as possible for themselves. They referred to seeking people's consent before providing care, explaining what they were about to do and maintaining people's privacy and dignity.

We recommend that the registered manager refers to relevant national guidance in order to develop a way to demonstrate a more systematic approach to the monitoring of records, events and the completion of cyclical tasks.

This section is primarily information for the provider

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 11 HSCA RA Regulations 2014 Need for consent The rights of people who use the service may not always be protected because it was not always clear that care and treatment was provided with the consent of the relevant person.