Redspot Care Limited

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Inspection report

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09 April 2019
11 April 2019
16 April 2019
17 April 2019
18 April 2019

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Redspot Care Limited provide personal care to people living in their own houses, flats and specialist housing. This is a domiciliary care service and primarily provides a service to older people, older people living with dementia or who may have a physical disability. At the time of inspection there were 46 people using the service.

People's experience of using this service:
People's comments about staffing levels were variable. Staff did not always have the time to give people the care and support they needed.

People and relatives told us call visits were for the convenience of staff, with people's call time preferences often ignored. People received inconsistent call visits from staff, some being too early or too late. People were often not informed about staff changes and who may be visiting or caring for them.

Recruitment checks for staff were not robust to ensure the right staff are recruited to support people to stay safe.

People were at risk because they did not always receive their medication or medicines as prescribed. Robust arrangements were not in place to effectively monitor the service's responsibilities and role in relation to medicines.

When things went wrong, there was little evidence of learning or action taken to make the required improvements. Investigations were not as thorough as they should be.

People were placed at potential risk of harm because not all staff had the skills and competence to recognise poor practice or to embed their training in line with best practice. Staff supervision and support was not consistent to monitor staff performance.

People's nutritional support was affected by the inconsistent call visit times by staff. People told us they could receive their meals too close together or not at all.

Staff did not always treat people with respect or dignity. People did not always feel well-supported or cared for. People were not always involved in decisions about their care.

Complaint arrangements were not robust. When people raised a concern or complaint, these were not always recorded, investigated thoroughly or responded to in a timely way. Not all people had confidence their concerns would be taken seriously.

There was a lack of consistency in how well the service is managed and led. The leadership and governance

arrangements were not effective or robust to ensure people received care and support that is person-centred and responsive to their needs.

People told us they were safe. The service had effective safeguarding arrangements in place to protect people from harm and abuse. People were protected by the prevention and control of infection.

Rating at last inspection:
This was the service's first inspection since being registered with the Care Quality Commission in March 2018.

Why we inspected:
This was a planned inspection in line with our scheduled inspection methodology.

Follow up:
For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led

Details are in our Well-Led findings below.

Redspot Care Limited

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) 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 Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was completed by one inspector.

Service and service type:
Redspot Care Limited is a domiciliary care agency which provides personal care to people in their own homes.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager managed the domiciliary care services based in Westcliff on Sea and Romford.

Notice of inspection:
We gave the service 48 hours' notice of the inspection visit because it is small, and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection site visit activity started on 9 April 2019 and ended on 18 April 2019. We visited the office location on 9, 11 and 18 April 2019 to meet with the registered manager and office staff; to review care records, policies, procedures and to provide feedback of our inspection findings. We spoke with people using the service or their representatives on 16 April 2019 and with staff on 17 April 2019.

What we did:
We reviewed the information about the service in the form of statutory notifications received from the service and any safeguarding or whistleblowing incidents, which may have occurred. A statutory notification is information about important events, which the provider is required to send us by law.

We spoke with five people who used the service and five relatives about their experience of the care provided. We emailed six members of staff so that we could speak with them about their experience of what it is like working for the domiciliary care service, but only two members of staff responded and contacted us. We also spoke with the registered manager and care coordinator. We reviewed five people's care files and three staff recruitment files. We also looked at a sample of the service's quality assurance systems, the registered provider's arrangements for managing medication, staff training records, staff duty rotas, and complaint and compliment records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Assessing risk, safety monitoring and management; using medicines safely; learning lessons when things go wrong

• Risk assessments were in place relating to people's moving and handling needs and environmental risks. However, other risks relating to people's health and wellbeing, for example where a person had a catheter or stoma fitted or where bedrails were in place, had not been considered.

• The 'spot visit' record for two members of staff stated they had not used the correct item of equipment for one person when providing moving and handling support. The outcome of the observation recorded that both members of staff should receive additional moving and handling training. No information was recorded to evidence this had been followed-up and refresher training provided to ensure lessons were learned. We discussed this with the registered manager and they told us they were not aware of this incident.

• Medication practices did not ensure people received their medication as they should. One person told us, "The carers do all my medicines, but I don't always get them when I am supposed to, I have some very strong medication."

• The Medication Administration Record [MAR] and daily notes for one person showed they were prescribed a medicine which must be given at a certain time to relieve severe pain symptoms. The person told us, "I am supposed to have it every 12 hours, but I can go longer, or I get it [medicine] too soon. When it's sooner I don't always swallow it and I keep it for later and take it when I should." Records showed the person did not receive their prescribed medicine on two occasions over a three-day period. Because of these omissions the person using the service was found to be in pain when staff next visited. Records showed this medicine was routinely not administered in line with the prescriber's instructions [12 hourly intervals]. The registered manager was requested to raise a safeguarding concern to the Local Authority and Care Quality Commission. At the time of writing this report the safeguarding information had not been submitted to us.

• The MAR for one person showed the code "O: other please write" was recorded for several entries, but no rationale recorded to confirm why the medication had been omitted by staff. The medication audit dated 28 Mach 2019 did not pick this up. This was not an isolated occurrence.

People's care and support needs were not provided in a safe way and not all risks to people were recorded. Safe medicine practices and procedures were not always followed. This demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

• People told us staff did not always arrive on time or stay for the allocated time as detailed and agreed within their support plan. People told us this impacted on their safety and wellbeing. One relative told us, "I

don't have any idea what time my relative's calls are supposed to be, the staff seem to come when they want. We have had missed calls and when I have queried this, I was told the carer must have forgotten to fill the book in. Due to my relative having dementia, they need consistency with their care and this is definitely not happening." One person using the service told us, "I have carers twice a day, but they [staff] come at whatever time suits them." Another person stated, "It depends how busy they [staff] are as to how long they stop, sometimes it's just in and out."

• People told us they were not always notified if staff were running late and did not always know who was going to provide their care and support. One relative told us their family member was often upset because of having staff they did not know. The relative told us, "I never know who is coming and what time, I can't relax till they [staff] have been." Another relative told us, "I never know when they [staff] will be coming, so we can't plan to do anything on a regular basis. If I knew what time the calls were, I could nip out to do a few errands. I can't as I don't want to leave [relative] on their own for longer than I need to."

• People's communication books confirmed what people told us about call times. For example, one person's care plan detailed they received four calls a day. The person's preferred times were recorded with their first and last call by staff being between 8.30am and 9.15am, 8.00pm and 8.30pm. The communication books showed their first call could be as early as 6.00am and their last call as late as 11.00pm.

• Staff recruitment practices were not safe and operated in line with the registered provider's own policies and procedures or with regulatory requirements.

• Written references were received after staff commenced in post and did not always include references from their most recent employer.

• Where a person had been previously employed, the rationale of why that employment had ended was not routinely recorded.

• The 'criminal conviction declaration' within one person's application form was not completed, however their Disclosure and Barring Service [DBS] certificate showed they had incurred several convictions. A risk assessment was not completed to demonstrate how their conduct was to be monitored during their probation period and until the registered provider and manager were satisfied with their performance.

• The recruitment file for one member of staff was requested on 11 April 2019, but at the time of writing this report this information had not been provided to us. Although the member of staff was not providing care to people using the service, they were privy to people's confidential information.

• A written record was not completed or retained to demonstrate the discussion had taken place as part of the interview process and the rationale for staff's appointment. This showed robust measures had not been undertaken to enable the registered provider to make an initial assessment as to the applicant's relevant skills, competence and experience for the role and; to narrow down if they were suitable.

The service did not ensure staff have time to give people the care and support they need. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Required staff recruitment checks were not always made and these arrangements were not safe or robust. This demonstrated a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

• People and those acting on their behalf, told us they felt safe.

• Staff spoken with had a good understanding of what to do to make sure people were protected from harm or abuse. Staff confirmed they would escalate concerns to the office, registered manager and external agencies, such as the Local Authority or Care Quality Commission. Staff confirmed they had received up-to-date safeguarding training.

Preventing and controlling infection

• People told us staff wore aprons and gloves when providing care and staff confirmed they had enough supplies of Personal Protective Equipment [PPE]. One person told us, "All the girls wear gloves when doing everything."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience
• Staff received mandatory training opportunities. However, not all staff had evidence of practical manual handling training. As already stated concerns about staff's manual handling practices had already been raised.
• Staff received an induction comprising of mandatory training aligned to the 'Care Certificate.' The 'Care Certificate' is a set of standards that social care and health workers should adhere to in their daily working life. Not all newly employed staff members' files viewed had evidence of a completed workbook to verify all parts of the 'Care Certificate' had been completed and they were now judged competent to undertake their role.
• No documented induction was evident for the domiciliary care agencies administrator. They had no previous care experience and were auditing people's communication books and Medication Administration Records [MAR].
• Where staff were promoted or assigned a different role, there was no evidence to show they received a robust induction to that role. An existing member of staff was given the role of care coordinator in September 2018. No induction to this role was recorded. The registered manager told us support was given by them and by another manager based at the Redspot Care Limited office in Romford.
• Supervisions were not completed on a regular basis, allowing staff the time to express their views and reflect on their practice. These comprised mainly of 'spot check visits.' The latter is where the provider's representative calls at a person's home just before, during or after, a visit by a member of care staff. This is so they can observe the member of staff as they go about their duties and check they are meeting the organisation's standards and expectations. Where areas for improvement were highlighted, these were not followed up for action and lessons learned.

Not all staff had evidence of a comprehensive induction or up to date training. Staff supervision and support is not consistent and does not meet staff's needs. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff were given the opportunity to shadow a more experienced member of staff depending on their level of experience, competence and professional qualifications already attained. One member of staff told us this was a positive experience.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• The service did not assess people's needs prior to agreeing and commencing the care package. The registered manager confirmed they relied heavily on the assessments provided by the Local Authority to

provide information relating to people's individual care and support needs.

Supporting people to eat and drink enough to maintain a balanced diet
• People told us staff supported them as needed with the provision of meals, snacks, and drinks throughout the day to ensure their nutritional and hydration needs were met. However, where staff did not always arrive on time and were running late, this could impact on people's mealtimes. One person told us, "I have what I want to eat, and the girls get it for me, but it can sometimes be too soon after breakfast for my lunch, so I am not always hungry." This concurred with entries recorded within people's daily communication book.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People had access to health professionals as required. If staff were concerned about a person's health and wellbeing they would relay these concerns to the domiciliary care office or the registered manager for escalation and action.

Adapting service, design, decoration to meet people's needs
• The domiciliary care service office was suitable for people who are both ambulant and who may have a physical disability. The office was on a main bus route and a short distance from a mainline railway station.

Ensuring consent to care and treatment in line with law and guidance

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.

• Staff had received Mental Capacity Act 2005 (MCA) training and were able to demonstrate an understanding of the requirements of the Mental Capacity Act 2005 and what this meant for people using the service.
• Staff provided examples of how they upheld people's rights to make choices and decisions.
• Improvements are required to ensure people's capacity to make decisions is clearly recorded.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity; respecting and promoting people's privacy, dignity and independence

• People were not always treated with respect and dignity as the support provided by some members of staff was inconsistent. This referred to staff not always arriving on time or staying for the allocated time as detailed and agreed within people's support plan. People told us they were not always notified when staff were running late and did not always know who was going to provide their care and support.

• Peoples comments were variable about the care and support provided. Although, people using the service and their relatives said staff were kind, our findings did not suggest a consistent caring service.

• Where comments were positive these included, "My regular girl couldn't be better and knows what I want before I do myself. Nothing is a trouble to her, I wish she could come to me every time she is working" and, "When the girls have been I always feel better."

• Where comments were not so favourable, these included, "I rely on the carers for everything. If I don't remember to ask them [staff] to leave a drink or they forget, I don't have one until they come in next visit" and, "I don't like to say anything because everyone is so busy. I don't usually know who is coming, so sometimes I don't go in the shower for a few days unless I have one of my regular girls. I get embarrassed and I feel uncomfortable with strangers."

• None of the people or relatives spoken with would recommend the service to others. More than one person told us they were in discussion with the Local Authority to try and find another domiciliary care agency to look after them or their relative. This was to ensure they got the care they needed, at the time they wanted and in line with their preferences and wishes.

Supporting people to express their views and be involved in making decisions about their care

• People and their relatives stated they had little input and involvement in the development of the support plan. Not all were signed to show the information recorded had been agreed.

• People and their relatives had been given the opportunity to provide feedback about the service through the undertaking of satisfaction questionnaires and periodic reviews.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Improving care quality in response to complaints or concerns
• People and their relatives did not always feel confident to raise concerns or make a complaint. People were not assured that their concerns were taken seriously, robustly investigated or responded to in a timely manner. One relative told us, "I regularly complain and the last time I had reason to, it took nearly eight weeks to get an acknowledgment from [name of registered manager]." They told us the rationale provided by the registered manager for the delay was due to people being on holiday or unwell. They stated, "It's not really good enough but what can we do. I have no real contact with the office other than to complain because I never get any joy."
• The complaints log provided by the registered manager showed since September 2018 there had been seven complaints made to the domiciliary care service. However, it was apparent from talking with people and their relatives that this log was not reflective of all concerns or complaints made about the quality of the service provided.
• A report by the registered manager to the Local Authority confirmed the management of complaints had not been robust and significant improvements were required to evidence lessons learned. The report confirmed not all concerns or complaints were being recorded by the care coordinator and passed to the registered manager. We discussed this with the registered manager and they advised the care coordinator was no longer responsible for the service's complaints management.
• Not all information relating to each complaint was available, therefore it was not possible to determine how outcomes had been reached.

An effective system for recording, handling and responding to complaints by people using the service or others was not in place and improvements were required. This demonstrated a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Support plans covered all aspects of a person's individual needs. This included the level of support required, the number of staff required to provide support each visit, the length of time for each visit, call time preferences and additional duties and tasks to be undertaken, such as housekeeping or shopping.
• Not all support plans were accurate and contained up-to-date information. For example, the care plan for one person dated January 2019, showed they were assessed as requiring three calls a day from staff. However, daily communication records showed this was increased to four calls a day in March 2019. The person's support plan was not updated to reflect this.

End of life care and support
No one using the domiciliary care agency was assessed as being at the end of their life. The registered manager advised where people required end of life care support, the domiciliary care service would work

with healthcare professionals, including palliative care specialists and others, to provide a dignified and pain-free death that is as comfortable as possible.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Planning and promoting person-centred, high-quality care and support with openness; how the provider understands and acts on their duty of candour responsibility; managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• Not all people or relatives spoken with believed the service was well-led or managed effectively. People had variable views about the quality of the service provided by the domiciliary care service. This meant there were variations in people's overall experience of using the service.

• The leadership and overall management of the domiciliary care office over several months did not ensure good outcomes for people using the service. Evidence as detailed within this report demonstrated there was a lack of openness and transparency, for example, complaints management.

• Lessons had not always been learned as failings identified had not been successfully addressed by the registered provider and manager to make the required improvements.

• Areas which needed improvement at this inspection included, risk and medicines management, ensuring people received care and support by staff in a timely way and not for the convenience of staff. Significant improvements were required to the service's complaints management. It was difficult to determine if the induction arrangements for staff were robust, given the lack of available evidence. Staff did not receive regular support, such as formal supervision to support performance monitoring. The registered provider's and manager's arrangements for identifying and managing the above were not robust or effective.

• Inspection findings as detailed within this report demonstrated not all staff in key positions understood their roles and responsibilities. There was little evidence to show they had been given honest feedback relating to their performance or where improvements were required. There was no documented evidence to demonstrate the improvements required and how their performance was to be effectively managed and monitored.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; continuous learning and improving care

• Arrangements were in place for gathering people's views of the service they received and for their relatives and staff employed at the service.

• 28 questionnaires were sent out in January 2019 to people using the service, with 19 questionnaires returned. An analysis of the information was compiled and although this highlighted both positive comments and areas for improvement, an action plan was not completed detailing how the improvements were to be made. The registered manager confirmed 30 questionnaires were sent out on 1 April 2019 to people using the service.

• A staff questionnaire was completed in 2019. Although the questionnaires highlighted both positive comments and areas for improvement, an analysis of the outcomes and subsequent action plan was not

completed detailing how improvements recorded were to be made.

Effective arrangements were not in place to assess and monitor the quality of the service provided to ensure compliance with regulatory requirements. This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff stated they enjoyed working for the domiciliary care service and received good support.

Working in partnership with others

● The service was able to demonstrate they were working in partnership with others, such as social workers and healthcare professionals.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not completed for all areas of risk. Not all was done to mitigate potential risks for people using the service by ensuring equipment was used in a safe way. Medicines management required improvement.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Effective arrangements were not in place for recording, handling and responding to complaints by people using the service and others acting on their behalf.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Arrangements to monitor the quality of the service for people using the service were not effective and improvements were required.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not operated effectively to ensure compliance with regulatory requirements.

Regulated activity	Regulation

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Improvements were required to ensure people receive a consistent and reliable service from staff. Appropriate arrangements must be in place to ensure staff have an induction which prepares them for their role and they receive regular supervision.