North Yorkshire County Council

Ryedale House

Inspection report

Old Malton Road
Malton
North Yorkshire
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

North Yorkshire County Council operate Ryedale House. This service is registered to provide personal care to people in their own homes within the communities of Malton, Pickering and the surrounding areas. The service can provide support for a maximum period of six weeks after referral to help people rehabilitate and increase their independence or long term to help people stay at home. At the time of the inspection the service was supporting 15 people in the community.

At the last inspection, the service was rated 'Good'. At this inspection we found the service remained 'Good'.

There was a registered manager at this service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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. Throughout this report we will refer to the registered manager as 'the manager'.

People told us they felt safe and well supported by staff from the service. The provider followed robust recruitment checks, to employ suitable staff, and there continued to be sufficient care staff employed to ensure home visits were carried out in a timely way. People's medicines were managed safely.

Staff continued to receive appropriate training to give them the knowledge and skills they required to carry out their roles. This included training on the administration of medicines and on how to protect people from the risk of harm. Staff received regular supervision to fulfil their roles effectively, and had yearly appraisals to monitor their work performance.

People were supported to have choice and control of their lives and the policies and systems in the service supported this practice.

Where staff prepared and cooked meals for people, people told us they enjoyed good food. People and their relatives gave us positive feedback about staff and described them as "Friendly, kind and considerate."

Staff knew about people's individual care needs and care plans were person-centred and detailed. We were told staff treated people who used the service with compassion, dignity and respect.

People told us that the service was well managed and organised. The manager assessed and monitored the quality of care provided to people. People and staff were asked for their views and their suggestions were used to continuously improve the service.

Further information is in the detailed findings below

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Ryedale House

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 15 August 2017 and it was announced. The provider was given 48 hours' notice because the location provided a domiciliary care service and we needed to be sure that someone would be in the office.

The inspection was carried out by one adult social care inspector and an expert-by-experience. The inspector visited the service office and completed visits to people's homes with their permission. The expert-by-experience carried out pre-arranged telephone calls to other people who used the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we looked at the information we held about the service, which included notifications sent to us since the last inspection. Notifications are when providers send us information about certain changes, events or incidents that occur within the service. We also contacted North Yorkshire County Council (NYCC) safeguarding and commissioning teams. We had not requested the provider to submit a provider information return (PIR). The PIR 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.

At this inspection we spoke with the manager and four members of staff. We visited two people who used the service who said they would be happy to meet and speak with us. We also spoke with a further six people on the telephone.

We looked at two people's care records, including their initial assessments, care plans and risk assessments. We looked at medication administration records (MARs) where staff were responsible for administering medicines. We also looked at a selection of documentation pertaining to the management and running of the service. This included quality assurance information, audits, recruitment information for two members

of staff, staff training records, policies and procedures, complaints and staff rotas.

Good

Is the service safe?

Our findings

People who used the service said they felt safe, confident and happy when being supported by staff from the service. Comments included, "Yes I do, there's been nothing wrong at all," "I feel safe and I trust them in my home," and "Very safe, I trust them when they're here."

Staff received training on making a safeguarding alert so they would know how to follow local safeguarding protocols. Staff told us they would have no problem discussing any concerns with the manager and were confident any issues they raised would be dealt with immediately. There had been no safeguarding alerts or whistle blowing notifications raised in relation to the service in the last 12 months.

Each member of staff had access to information relating to key policies and procedures, such as health and safety, whistleblowing, first aid, fire safety, medicine management, personal care and safeguarding adults and children.

Staff told us they felt their safety at work was important to the service. All staff were provided with mobile telephones and logged on when they left home. They documented what roster they were following and the route taken and their name. This was part of the 'safety in rural areas' process put into place by the service. One member of staff told us, "When you finish your shift at 22:00 you text to say you are home safe. This is just part of their support network for staff."

The service employed 32 staff members and each week they had their own roster emailed to them, with the times and dates of visits to be carried out. The normal operating hours for the service was from 07:30 to 22:00, although people who used the service and staff had an 'out of office hours' emergency contact. People who used the service and relatives told us that staff were always on time. One relative told us, "Staff always turn up at the same time. Once they were late because of an emergency and they rang me to let me know. They always do a proper job, they don't rush off but stay the full time." The call logs we looked at showed there had been no missed calls since April 2017. This indicated the service was being monitored and was well managed.

There were risk assessments in place that recorded how identified risks should be managed by staff. These included the environment and any risks due to the health and support needs of the person; the risk assessments had been updated on a regular basis to ensure that the information available to staff was correct. Accidents and incident records were sent to the provider's head office for analysis and the manager received feedback from the provider's health and safety officer. They also received any serious untoward incident information back so this could be disseminated to staff in the team meetings. This demonstrated that risks were monitored and learning from mistakes was a key focus of the service.

We saw sufficient staff were deployed to meet people's needs. People who used the service provided consistently positive feedback about staff's reliability and punctuality. People told us that they received support from different care staff, but were happy with the service. Comments received included, "Two men and two women have been coming, it's always one of them, they're all very nice", "Quite a few staff come, so

many different ones, you forget. I don't mind they are all very good," and "Different staff turn up, they introduce themselves and tell me who they are."

The service had two staff teams. The North team had one team leader and eight full time equivalent members of staff, whilst the South team had one team leader and 9 full time equivalent staff members. Team leaders were responsible for managing staff rosters, staff meetings, carrying out staff supervisions and appraisals and overseeing staff attendance and performance. The North team also had one full time equivalent independence coordinator and the South team had two. These staff were responsible for carrying out assessments of need for people who wished to use the service and also equipment assessments. The independence coordinators held their own caseload of people who used the service and they were responsible for carrying out reviews of care at the end of the package of support. They were also responsible for updating the care plans and completing risk assessments.

Robust recruitment practices were followed to make sure new staff were suitable to work in a care service. These included application forms, interviews, references and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups.

The arrangements for managing people's medicines were safe. Staff received training to handle medicines, and medicine administration records (MARs) we reviewed were correctly completed. All staff completed a medicine competency check annually and the evidence of these were seen in the staff files we looked at. The manager, or one of the team leaders, carried out a monthly audit of the medicines. Stock checks were completed by the team leaders to ensure safe practices were being followed. One person who used the service told us how medicine management worked for them. They said, "They see I get my tablets and write it down in the folder."

Good

Is the service effective?

Our findings

People who used the service and their relatives were extremely positive about the support and care they received. They told us, "I think staff have the right skills and experience to look after me. Some of the young ones are a bit unsure at first but they come with someone more experienced until they have learned the job," and "They seem to know what they're doing, no mistakes or accidents. They are confident and very good at what they do."

The staff induction included two days of classroom training. Staff had the opportunity to complete the care certificate if they did not already hold a national vocational qualification (NVQ) in care, or its equivalent. During their induction staff completed training in first aid, moving and handling and medicines management. They were able to shadow more experienced staff until their training was completed. New staff were mentored by members of the established teams and the team leaders. The manager received feedback from the team and team leaders on the new starters performance. New staff only worked on their own once their training was completed and the manager was confident about their practice.

The provider ensured staff completed a range of training. Training included on-line and practical courses on topics which included safeguarding vulnerable adults, infection prevention and control and fire safety. Each staff member had their own learning and development plan on the training website. Staff told us about their learning and development and said, "We use the on-line system for training. We complete a set list of required subjects and it goes red on the page if any of these needs doing." The manager received a report from this which showed which staff had completed what training and where any gaps were. The training website sent emails to the manager and staff when refresher training was due.

Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. Staff completed an observational supervision session and two monthly face-to-face supervisions each year, plus an appraisal. The manager carried out these for the team leaders who then completed supervisions for the rest of the two teams. Staff said they were well supported by the management team. Supervision was a two way process where they were able to discuss any concerns they may have and anything raised was acted on.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. Where people live in their own homes, applications to deprive a person of their liberty must be authorised by the Court of Protection.

We checked whether the service was working within the principles of the MCA. We found that training was provided for staff on the MCA. Staff we spoke with showed they understood the importance of consent and we saw that capacity issues were explored when planning people's packages of care and support. People

who used the service were asked to sign their care records to document that they consented to the care and support provided. At the time of our inspection no one who used the service was deprived of their liberty.

Staff said they felt there was very good communication between themselves and the office. They told us, "We use group texts to make sure everyone gets important information and changes to work" and "Our rosters are sent to us every Thursday or Friday for the following Saturday. These are e-mailed to each staff member and the office text us with any changes or they will issue us with a new roster. We check our emails daily, but also get alerted through the texts."

Emergency contact details for people's GPs and other professionals involved in their care were recorded in their care records. Staff were confident when talking to us about what to do in an emergency. One person who used the service told us, "Yes, all the staff are very nice; I'm looked after very well. They're ever so good. One teatime I felt poorly and the carer got the doctor for me and called my daughter."

Staff provided effective support to ensure people ate and drank enough. People told us, "Staff make my meals three times a day. I usually have microwaved ones. It's always nicely done and the food and drinks are hot. They tidy up the kitchen afterwards" and "They make my meals at breakfast and dinner time - usually ready meals. The meals and my drinks are always how I like them." One person who spoke with us was not happy about their meals and their concerns were passed onto the manager who said they would speak to the person and address their issues.

Referrals to the service could be received from a variety of sources including direct from the public, GPs, district nurses, hospitals, the mental health team or families. Each person wishing to use the service was given a leaflet about the service and then signed a consent form. As part of the start-up package the people who used the service received contact details for the office. There was a sticker with this information in the front of each care file.

The independence coordinators had completed advanced moving and handling training and equipment training to enable them to carry out robust assessments. The service could supply equipment on a long-term basis and this could be arranged over the phone. The independence coordinators then went out to people's homes to ensure the equipment was correct and fitted appropriately. The estates team for Scarborough Council were in charge of fitting equipment for the service.

Good

Is the service caring?

Our findings

We visited two people in their own homes. Both were extremely pleased with the service, but sorry that it was for such a short time. One person said, "I am very happy with the service and staff. They encourage me to do as much as I can for myself and prompt me when I forget things."

Other people who spoke with us said, "Staff are definitely caring. Very nice, kind and gentle, all of them. I would recommend them to anybody. They are very friendly. They call us by our preferred names" and "They are all very nice, they are all different but very good, I can't fault them. They encourage me to do things for myself. I can put my socks on now and cream my legs myself. They stand and watch me while I take my medication and supervise me when I'm making a meal."

The remit of the service was to provide up to six weeks of care and support for people to aid them in regaining their independence. There was some leeway with this. The service reviewed people's care needs at the end of the support package and worked with the Planned Care team to direct people to other domiciliary care services for on-going support.

People who used the service were supported by two small teams of staff who covered each other for leave or sickness. This meant people received a continuity of care from staff who they knew and trusted. People said, "Yes. They are very good. They sit and talk to me, if I have any questions they try and answer them. They always ask me if I need anything else doing before they go. They are all like that; I couldn't pick any of them out" and "The level of care more or less depends who comes. It's a different one every day. Some are more amenable than others, but they are all okay."

Staff told us that it was possible to change who they attended to if they felt there was a personality clash or if someone got on better with another member of staff. Times of visits were not specified unless the person had a medical condition that required time sensitive support. One person who used the service said, "I usually ask them who is coming on the next visit and they tell me who it will be." Staff told us that each call was usually half an hour to an hour long. One staff member said, "If I noticed any change to people's care was needed then I would call the independent coordinator and they would come out to reassess the person."

People told us staff treated them with respect and provided care and support which maintained their privacy and dignity. Feedback included, "They respect our home, tidy up after themselves and clear their gloves and aprons away", "When they take me to the toilet they always close the door for privacy. At first a young man used to come to put me to bed. He asked if I minded, I said it was ok, I got used to it in hospital. They look after my place and always tidy up after themselves" and "They don't just walk in but open the door and say I'm your carer and I tell them to come in."

People were supported to be involved in planning their care and support and making decisions about how their needs were met. People who used the service explained that they were involved in setting up their package of care to ensure it met their requirements. They told us their wishes and views were listened to

during this process. This showed us that people who used the service were supported to be in control and make decisions about their care and support.

The provider had a policy and procedure for promoting equality and diversity within the service. Discussion with staff indicated they had received training on this subject and understood how it related to their working role. People told us that staff treated them on an equal basis and we saw that equality and diversity information such as gender, race, religion, nationality and sexual orientation were recorded in some of the care files.

The manager understood the role of advocacy and had contact details available if anyone who used the service required the support of an independent advocate. An advocate is someone who supports people, particularly those who are most vulnerable in society, to ensure that their voice is heard on issues that are important to them.

Good

Is the service responsive?

Our findings

People and their relatives told us the service was responsive to their needs and staff went out of their way to assist them with any problems or changes to care and support that they might require. The manager told us that they constantly monitored the input from their staff and used feedback from reviews to reassess the current care packages. Staff told us that they gave feedback to the office if the person receiving the service was doing well and there was evidence that they no longer needed the service.

A needs assessment had been carried out to identify each person's support needs, and care plans had been developed outlining how these needs were to be met. People had written copies of their risk assessments and care plans in their own homes. Another copy was kept in the services' office in an on-line format. People had signed their care plans to show they had been developed with the person and agreed. We saw that care plans and risk assessments had been reviewed to make sure they contained relevant information and were up-to-date. People said they felt included in their care and support and told us, "I think so. I talked about what help I needed and wrote it in the book which they keep here" and "Yes the care I am getting covers everything I need help with at the current time."

The service provided different care packages depending on the needs of the individual. Some people just required an assessment for equipment to enable them to retain their independence, whilst others needed short term care to get them back on their feet again. The service was free to those using it. People told us, "Someone came to assess me when I was in hospital, my daughter sorted it out." and "I think they came to see me in hospital, I have had them for five weeks and think you have to pay after six weeks. I think someone is coming this afternoon to reassess me."

There were good communication links between the different staff teams and the services' office. Each member of staff was issued with a mobile phone as part of the service's lone worker policy. Staff told us they would ring the independence coordinators and use texts and voice mail to pass information from one shift to another where any changes to care were noted. Staff also spoke with us about recording in the care files and completing the daily record sheets, so there was an up to date record of support given to people who used the service. Staff told us, "We discuss information at our weekly team meetings, which means everyone knows what is going on."

Every day staff were updated with rosters which listed new people starting the service. Key codes for gaining entry to people's homes were kept protected on-line and texted to staff as needed. The name and address of the person was never included in the same text as the key code information for security. One member of staff said, "There is a bullet point box on each rota that new information is put into. We make sure we read the care plans which are usually in people's homes." People who used the service told us, "Staff always write in the folder when they have been. When they come they look to see what the others have written" and "Staff write what they do and they read the notes in my folder to find out what's happened before."

The provider had a policy and procedure in place providing details about how they managed and responded to complaints about the service provided. We saw that details about the provider's complaints

procedure was kept in people's care files in their own homes and a copy was available at the office site.

No complaints had been received in the last year, although some people were disappointed when the service was withdrawn at the end of the six weeks. For example, one person told us they had been with the service for about three weeks. They said, "One of my daily visits has been withdrawn, which I am not happy about. They say I don't need it, but I think I do." They agreed that we could pass on their concerns to the manager, who said they would ring the person and discuss their issues.

The manager said any formal complaints would be dealt with by them and also directed to the provider's head office. People told us, "I have never needed to complain, but I would feel okay about speaking to the care staff", "I have never had any complaints whatsoever, they have been absolutely lovely. I would not be afraid to speak up if there was a problem" and "No concerns, but if I had I would look in the book to see who to contact."

Good

Is the service well-led?

Our findings

There was a manager in place who was registered with CQC. They were supported by the independence coordinators and team leaders both in the office and out in the community. One member of staff told us, "The manager is really good. I would have no hesitation in contacting them if I had any issues to discuss. They are very accessible to staff."

During the inspection we received consistently positive feedback about the service provided. Comments included, "The service is well organised, they all seem to get on and work as a team", "I think they are effectively managed, they seem to get on well together" and "They seem to be organised and know what they are doing. They do a good job."

Our observations of the staff workforce indicated that they were all motivated to support people to the best of their abilities. They were caring, patient and kind with people who used the service. Their discussions with us showed they had good insight into what people wanted from the service and how to achieve this.

We observed that the culture of the service was customer based and focused on providing person-centred care. People who spoke with us were full of praise for the service and said they would recommend it to others. We were told, "I would definitely recommend the service. They are brilliant", "They make sure I have everything I need and everything is okay, they have been marvellous" and "Yes, they are very good, very kind; they'll do whatever you need."

The manager told us that feedback from people who used the service, relatives and staff was obtained through care reviews, day-to-day business and weekly staff meetings. This was confirmed by people who used the service. One person told us, "Staff ask me if I am happy with the service; I tell them everything is okay." The manager told us that they or another member of the management team spoke face-to-face with people about any changes happening with the service. This was confirmed by the people we met and spoke with during the inspection.

We were given copies of team meeting minutes. Staff told us these were really useful. They received updates of any new people using the service during the meetings. Team meetings were held every one to two weeks at Ryedale House. One member of staff said, "We get feedback at the meetings and during conversations in the office." Another said, "The meetings cover all aspects of the service and are an open forum where any concerns or queries can be raised and discussed."

Quality audits were undertaken to check that the systems in place at the service were being followed by staff. The manager carried out monthly audits of the systems and practice to assess the quality of the service, which were then used to make improvements.

Missed calls were identified through staff and people notifying the service. These were addressed through the management team speaking to the member of staff. The manager completed a monthly report of the service with the information being sent to the service manager and head of operations. Any learning from

events were itemised in the report and this section went onto the team meeting agendas.

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.