GP Homecare Limited
Radis Community Care (Tamworth)

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<tr>
<th>Region:</th>
<th>West Midlands</th>
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| Location address:       | 6 Pebble Close Business Village  
|                         | Amington      
|                         | Tamworth  
|                         | Staffordshire 
|                         | B77 4RD       |
| Type of service:        | Domiciliary care service  
|                         | Extra Care housing services |
| Date of Publication:    | March 2012    |
| Overview of the service:| Radis provides personal care to people in their own homes. |
Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Radis Community Care (Tamworth) was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 22 February 2012, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We visited this service as part of our scheduled programme. We had also received information from the local authority that some people were not receiving a safe, effective service. This was an unannounced visit and the service did not know we were visiting.

We spoke with people and relatives about the service they received. Most people were pleased with the support they received although some people said they would like to have more regular carers. People were particularly complimentary about their regular carers. Comments included, "Marvelous" and, "Staff very kind". Some people raised some concerns about the service when their regular care worker was not present. One person told us they cancelled the service when their regular care worker was away. They did not feel a new care worker would understand their relative’s needs.

People were generally happy with the times of their calls and felt that care workers had sufficient time to provide the support they needed. People felt that staff provided their care in a manner that respected their privacy and dignity.

Everyone had a plan of care but these were centred around the tasks and provided little information about how people wanted their support to be provided. There was also limited information about how staff should support people with dementia care needs.

Most people said they were happy with the support they received to have their medication. However safeguarding issues had been raised in respect of medication administration and two people we spoke with identified issues about the support they received to have their medication.
The service had systems in place to review and monitor the service but over recent months some of these had lapsed due to staffing issues. The service had recently started to address such areas as telephone monitoring, spot checks and reviews.

**What we found about the standards we reviewed and how well Radis Community Care (Tamworth) was meeting them**

**Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights**

The current systems in place cannot ensure that people always receive the specific care and support they need.

**Outcome 09: People should be given the medicines they need when they need them, and in a safe way**

Current medication practices cannot confirm that everyone will have their medication as prescribed.

**Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills**

Although plans for training are in place people cannot yet be fully confident that all care workers will have the knowledge and skills to provide the support that will meet their needs.

**Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care**

Although the service has implemented processes to review and monitor the service people cannot yet be fully confident that they will benefit from appropriate care.

**Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential**

People cannot be confident that all records are held securely and are up to date and accurate.

**Actions we have asked the service to take**

We have asked the provider to send us a report within 7 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.
Other information

Please see previous reports for more information about previous reviews.
What we found for each essential standard of quality and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

**Compliant** means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*
Outcome 04:
Care and welfare of people who use services

What the outcome says
This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement
There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We spoke with ten people or their relatives about their experiences of the service.
Everyone told us they were very satisfied with the quality of their regular care workers.
One person told us that the care worker who came in the mornings was "marvelous".
Other comments included, "Main carers are excellent" and, "Very happy with the care".
Most people were satisfied with the care they received but everyone wanted regular carers.

Some people said that they had a number of different care workers in the evenings.
One relative told us that they never knew who would come in the evenings. They also said that there had been times when the care worker had not known what support to provide. Some people commented on how much better it was if they had developed a relationship with the care worker. One relative said, "It is easier both for relatives and carers if they get to know them as sometimes they could be difficult. Carers who know them well understand them and know how they communicate."

People said that care workers treated them well and respected their privacy and dignity. Comments included: "They treat them nicely", and "Care provided discreetly".

People said that staff visited them to undertake an assessment before the service started. Most people also said they had a plan of care. Our examination of a sample of records showed that most contained an assessment and a care plan was completed. Plans of care were task focused and did not include specific information about the person to show how they wanted support to be provided. For example one plan
identified personal care as required but how the person wished this to be undertaken was not included. Care plans were signed by people to show their agreement to the service being provided. We saw little evidence that plans of care were being reviewed.

We saw some examples when the information in the plan of care did not correspond with the care provided. For example a plan of care stated food was needed at the evening call but there was no evidence that this was provided. In another instance the plan of care only identified a morning visit when the daily records showed that support was also being provided in the evenings.

The service had a risk management system in place and we saw that everyone had a risk assessment completed. We saw that the risk assessment relating to manual handling needed to be further developed. The manager did tell us that there were plans in place to address this.

The service provided care to a lot of people who had dementia care needs. We saw that this was included in the assessments but there was little information in the plans of care to show how the condition affected people. For example, we saw that one person could become agitated and aggressive but there was no information to show staff how to respond to this behaviour. One staff told us that they had asked to have training in dementia care to give them advice to respond to such incidents appropriately. Currently they relied on advice from other care workers. We also saw that some people required food and drinks to be provided but there was no information for staff on how to respond if they refused nutrition or said they had already eaten.

People told us that their care workers usually arrived around the correct time and had sufficient time to provide the support they needed. We saw that the times of calls were agreed with the person prior to the service starting. We did see some records that identified a specific time but the service was not being provided at this time. For example one person had arranged for a call at 18.30 but the call was never provided at that time. There was no information to show how or when the call time had been changed. Of the people we spoke to only one said they had ever had a missed visit and they stated that this was a very rare occasion. The service has advised us that there had been 13 missed calls since April 2011 (eight of them related to one care worker) and a number of late visits. They acknowledged that they had significant staffing problems over the last nine months although the situation had now improved.

We saw that until very recently staff had no time between visits. This would mean that staff would either cut short a visit or would be more progressively late for calls throughout the day. This has recently been addressed and time between calls has now been introduced. Staff we spoke with stated that in most instances this time was sufficient to arrive at the correct time.

Other evidence
The local authority informed us of a number safeguarding incidents relating to medication issues, late calls, a failure to follow the plan of care and professional conduct. The service acknowledged that there had been instances when care had not been provided at the standard required. They have put in place an action plan and we saw evidence that when concerns were raised the service acted upon them.

Care staff we spoke with stated that they mainly had regular people they supported.
They stated that a recently implemented roster was enabling people to have a more consistent service with regular care workers. 

We spoke with some health professionals. Their experiences of the service were positive. One person told us that the service had successfully provided people with end of life care. Another told us that they had worked closely with the service and had found staff to be very understanding and willing to work together. They said that when there were errors these were quickly addressed.

Our judgement
The current systems in place cannot ensure that people always receive the specific care and support they need.
Outcome 09:
Management of medicines

What the outcome says
This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

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<td>There are moderate concerns with Outcome 09: Management of medicines</td>
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<th>Our findings</th>
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<td><strong>What people who use the service experienced and told us</strong></td>
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<tr>
<td>We spoke with some people who were being supported with their medication. Most people were happy with the support they received. One relative commented that there had been occasions when care staff had forgotten to do the medication and another person identified occasions when they had not had their medication because the timing of the visits meant they was not a sufficient gap between doses.</td>
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| | We saw that everyone had a medication form that outlined the support to be provided and a list of medication. These forms were signed by the person concerned or their relative. We saw some instances when the medication recorded did not correspond with the medication being signed for on the medication administration sheet. For example the record of medication did not identify aspirin but this was being recorded as being given on the medication administration sheet. |
| **Other evidence** |
| We have received a number of safeguarding reports from the local authority that identify the management of medication as an area of concern. |

| | We saw records to confirm that all staff had received some training in medication. All staff we spoke with said they had received such training. The service currently had no recorded system in place to show that staff's competency to administer medication was assessed. Some staff did tell us that they had been observed as part of the spot checking system. |
The service told us it had a system in place to check all medication administration records. However they were behind on the checks due to staffing issues. This could mean that errors or poor practice may not be picked up. We did identify that when medication issues were raised that the service dealt with them promptly.

The service's own action plan identified medication as an area it needed to address.

**Our judgement**  
Current medication practices cannot confirm that everyone will have their medication as prescribed.
Outcome 14:
Supporting staff

What the outcome says
This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

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<th>Our judgement</th>
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<td>There are moderate concerns with Outcome 14: Supporting staff</td>
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<tr>
<td><strong>What people who use the service experienced and told us</strong></td>
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<tr>
<td>Most people we spoke with were complimentary about the quality of the care workers. People felt them to be friendly and caring.</td>
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<th>Other evidence</th>
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<td>The safeguarding information we have received shows concerns over the competency of some of the staff providing a service.</td>
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We saw evidence that all staff received induction training and completed a period of shadowing before working alone. We also saw evidence that the service had implemented a system of spot check although they did not identify whether the checks had covered such areas as medication administration. We also saw evidence that some staff had received individual supervision. Of the four staff files we checked there were records to show that two had received supervision.

All of the staff we spoke with confirmed they had spot checks to check their practice. Some confirmed they had individual supervision. All confirmed they had completed induction training.

Evidence from training records confirmed that a high number of staff required elements of training for people to be confident that had the skills and knowledge to undertake their role. For example 40% of the people receiving a service had dementia care needs but less that 25% had completed any training in this area. Daily records we saw for some people with dementia care needs did not evidence that staff were aware of all the issues in providing such care. We also identified issues with the quality of
assessments, recording, plans of care and risk assessments which indicated that staff required further training and support in these areas.

The service was aware of the need to address staff training and competency and identified this as part of their action plan. The manager confirmed that the main emphasis over recent months had been on ensuring the service was provided and therefore due to staffing levels less training had taken place. We saw that as the staffing levels had improved the service had started to address the training needs of the staff. The action plan confirmed that plans were in place to provide staff with training in risk management. The manager told us that dementia care training should start in May 2012. The service had also requested further training in safeguarding adults.

Our judgement
Although plans for training are in place people cannot yet be fully confident that all care workers will have the knowledge and skills to provide the support that will meet their needs.
Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says
This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

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<th>Our judgement</th>
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<tr>
<td>There are moderate concerns with Outcome 16: Assessing and monitoring the quality of service provision</td>
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<th>Our findings</th>
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| **What people who use the service experienced and told us**
Very few of the people we spoke with were aware that the service had monitoring systems in place. Of the people we spoke with two said they had received a spot check from the service. Most people did not know if their service had been reviewed.

**Other evidence**
The manager told us that they had a number of systems to review and monitor the service people received. The manager fully acknowledged that it currently did not have an effective system in place and has identified this area to be addressed within its own action plan.

The service completed a yearly survey of people using the service and this had recently been started meaning there were no current results. The service had a system of telephone monitoring that had restarted in January 2012. The action plan identifies that they have a weekly target of 20 calls a week. Information from this recent monitoring showed people were overwhelmingly positive about the attitude of care workers, about the punctuality of calls and about infection control practices. There was a significant percentage who said they did not have a regular carer.

The service told us that they checked every log book and medication administration sheet when it was returned to the office. This helped them to identify any issues or concerns both about the person using the service and about staff's competency. The service told us that due to recent staffing pressures they were considerably behind in this process and we observed stacks of log books, medication charts and other
documents that had not been checked. These mostly covered the period from December 2011.

In the files we examined we did not see consistent evidence of regular reviews of people's service and of risk assessments. We also saw examples of changes to the service when there was no information to identify the reasons for the changes. The service's action plan had identified a target of 18 reviews a week.

We did see evidence that when a concern was raised with the service an investigation took place and actions were taken to try and rectify the issue. We also saw that the service logged and acted upon complaints it received.

**Our judgement**
Although the service has implemented processes to review and monitor the service people cannot yet be fully confident that they will benefit from appropriate care.
Outcome 21: Records

What the outcome says
This is what people who use services should expect.

People who use services can be confident that:
* Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
* Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement
There are moderate concerns with Outcome 21: Records

Our findings

What people who use the service experienced and told us
People had information kept in their home and a copy within the office. We looked at a sample of care records in the office and we identified some errors and contradictory information within a number of files. For example records of medication varied and plans of care were not always updated to reflect the current service. We also identified that plans of care did not always provide sufficient information for staff to be aware of how people wished their care to be provided.

Other evidence
We saw that files were kept securely in the office in locked cabinets. We did however see daily logs and medication records that were not kept securely.

The manager was aware that there needed to be improvements in record keeping to make sure that information was accurate and up to date. As part of their action plan they have identified a need to ensure that medication changes were recorded and plans were improved to make sure they included more detailed information.

Our judgement
People cannot be confident that all records are held securely and are up to date and accurate.
Compliance actions

The table below shows the essential standards of quality and safety that are not being met. Action must be taken to achieve compliance.

<table>
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<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Personal care</td>
<td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 04: Care and welfare of people who use services</td>
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<tr>
<td></td>
<td><strong>How the regulation is not being met:</strong></td>
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<tr>
<td></td>
<td>The current systems in place cannot ensure that people always receive the specific care and support they need.</td>
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<tr>
<td>Personal care</td>
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<td>Outcome 09: Management of medicines</td>
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<td>Personal care</td>
<td>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 14: Supporting staff</td>
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<td><strong>How the regulation is not being met:</strong></td>
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<tr>
<td></td>
<td>Although plans for future training are in place people cannot yet be fully confident that all care workers will have the knowledge and skills to provide the support that will meet their needs.</td>
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<tr>
<td>Personal care</td>
<td>Regulation 10 HSCA 2008 (Regulated)</td>
<td>Outcome 16: Assessing and monitoring the quality of service</td>
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Action
we have asked the provider to take
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<th><strong>Activities) Regulations 2010</strong></th>
<th><strong>provision</strong></th>
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<tr>
<td><strong>How the regulation is not being met:</strong></td>
<td><strong>Although the service has stated to implement processes to review and monitor the service people cannot yet be fully confident that they will benefit from appropriate care.</strong></td>
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<tr>
<td><strong>Personal care</strong></td>
<td><strong>Regulation 20</strong> <strong>HSCA 2008</strong> <strong>(Regulated Activities) Regulations 2010</strong></td>
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<td><strong>How the regulation is not being met:</strong></td>
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The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 7 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.
What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called Guidance about compliance: Essential standards of quality and safety.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions:** These are actions a provider should take so that they maintain continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions:** These are actions a provider must take so that they achieve compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action:** These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.
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Citygate  
Gallowgate  
Newcastle upon Tyne  
NE1 4PA |