Review of compliance

GP Homecare Limited
Radis Community Care (Tamworth)

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<td>Location address:</td>
<td>6 Pebble Close Business Village Amington Tamworth Staffordshire B77 4RD</td>
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<td>Type of service:</td>
<td>Domiciliary care service Extra Care housing services</td>
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<td>Date of Publication:</td>
<td>September 2012</td>
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<td>Overview of the service:</td>
<td>Radis (Tamworth) is part of the Radis Community Care Group owned by GP Homecare Ltd. It provides care to approximately 200 people in their own homes in the Tamworth area and employs approximately 100 care workers.</td>
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Our current overall judgement

Radis Community Care (Tamworth) was meeting all the essential standards of quality and safety inspected.

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 to check whether Radis Community Care (Tamworth) had taken action in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 09 - Management of medicines
Outcome 14 - Supporting workers
Outcome 16 - Assessing and monitoring the quality of service provision
Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 4 July 2012, looked at records of people who use services and talked to staff.

What people told us

We spoke to two people about the service they received from Radis (Tamworth). One person told us “I don’t know how we’d manage without them”. He described the care workers as “brilliant” and said they helped with whatever they needed. Another person told us the service was excellent, particularly over the previous year. He said the care workers were all very pleasant and did what was needed.

We found that Radis (Tamworth) had developed a plan to improve their services in the last six months. They were assessing people’s needs and delivering personalised care. They worked with their staff to improve the support given to people when they took medicines. They were supporting their staff and had increased training opportunities. They monitored and reviewed their services to improve quality in all areas. Their record keeping and file management was good.

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 provider was meeting this standard. People's needs were assessed and care and treatment was planned and delivered in line with their individual plan.

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

The provider was meeting this standard. People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicine administration.

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

The provider was meeting this standard. People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

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

The provider was meeting this standard. The provider had an effective system to regularly assess and monitor the quality of service that people receive.

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

The provider was meeting this standard. People were protected from the risks of unsafe or inappropriate care and treatment.

**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.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
When we visited this service in February 2012, we had concerns about people's care plans. These lacked details of how people wanted their care to be delivered. In some instances there were discrepancies between what the plan said and the care given. The care plans did not show whether care workers had awareness about the needs of people with dementia. We could not be certain that the care given to people was at an acceptable standard. Some visits were missed or care workers arrived outside the specified times. We found the service non-compliant and asked the provider to draw up an action plan to demonstrate the improvements they intended to make.

When we returned to Radis (Tamworth) in July 2012, we reviewed the action plan with the registered manager to check what progress had been made. The manager told us that senior staff had received training on person-centred planning, personalised risk assessments and outcome-based reviews. We looked at the files for three people. People had input and choice over their individual plan. People using the service or their families had given their consent to the care package offered to meet those needs. We saw that senior staff known as field supervisors undertook initial assessments and checked back with people that the service provided was continuing to meet their needs.

We spoke to two people about the service they received from Radis (Tamworth). One person told us "I don't know how we'd manage without them". He described the care workers as "brilliant" and said they helped with whatever they needed. Another person told us the service was excellent, particularly over the previous year. He said the care workers were all very pleasant and did what was needed.
We spoke to a field work supervisor who confirmed that care workers were aware of how to complete the diary report books because they had been given examples to follow. Their entries were monitored weekly through a staff reviewing process based on the fieldwork supervisors reading all entries before filing them on the care files. We looked at the diary record books for three people. Carers had used these appropriately to record their activities and the person's responses. One care worker gave a thorough account of how she set up everything a person would need during the day; another care worker used a separate section of the log to record her concerns about an aspect of a person's medical condition.

We spoke to a senior care coordinator with responsibility for training. She had attended dementia training using a person-centred approach, delivered and certified by the provider organisation Radis Community Care. She had gone on to deliver dementia awareness training to three groups of Radis (Tamworth) staff while being observed by a trainer. The manager and the trainer told us that it was their aim that all staff would have attended dementia awareness training by the end of September 2012.

The manager told us that where people using the service lacked capacity, the service had actively involved their families to ensure that background information was correct and to ensure that their choices and rights were supported and maintained through their individual daily plan. We spoke to a third senior staff member, another field supervisor with responsibility for quality assurance. The fieldwork supervisor described her meeting with a relative of a person with dementia. We saw her record of this meeting in which she checked that the service provided met the person's needs and the quality standard expected by the service.

In respect of missed or mis-timed visits, the manager told us that schedules had been revised so that care workers had enough time to deliver a good standard of care for the time specified. We spoke to one care worker about this. She told us that she had a "packed" round sometimes making nine morning calls. She started work very early and said that some people liked this. She told us her schedule was manageable.

Other evidence
We did not look for other evidence in respect of the standard.

Our judgement
The provider was meeting this standard. People's needs were assessed and care and treatment was planned and delivered in line with their individual plan.
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

Our judgement
The provider is compliant with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
When we inspected Radis (Tamworth) in February 2012, we had concerns about how the service managed people’s medicines. We had not seen a system in place to show that care workers were competent to give medicines. The manager had explained that they had a system but that staffing shortages had meant that it was not being properly implemented. We had found some instances where medicines had been forgotten; medicines had been missed because care workers arrived too early or too late; and a medicine recorded as given which was not on a person’s list of medicines.

In the action plan drawn up following that inspection, it was stated that the medication reporting process had been reviewed and the medication policy had been re-issued to all staff. This included a new reporting procedure to capture all medication refusals and other issues and nominating a senior fieldwork supervisor with appropriate training and experience and available on a dedicated telephone line to provide an emergency response to people using the service, their families and care workers whenever a medication issue arose.

The action plan referred to a review of schedules to ensure that time critical medication calls show an alert on staff rotas. Adequate time was scheduled between calls to ensure effective medicines management.

Senior staff and care workers were informed about the changes at a series of staff meetings in March 2012. The manager delivered training sessions about the
expectations of all staff in respect of medicines administration. We saw evidence of this in the manager's report of the March staff meetings.

Letters had been issued to people and their families or other representatives advising them of the changes and asking them to communicate with the service about changes in required medicines or any concerns they had. We saw a copy of the letters sent dated 9 March 2012.

The nominated senior fieldwork supervisor monitored and followed up all incidents regarding medicines. The other six fieldwork supervisors were alert to any other medicines incidents recorded in diary records when they signed the records and filed them.

The training matrix showed that 43 staff had attended external training in management of medicines during the first half of 2012. Further training was arranged for staff during the later part of the year. Nearly all of the staff had attended the training delivered by the manager at the series of staff meetings in March 2012.

The manager acknowledged that issues have continued to arise in respect of the management of medicines. We have been made aware of three recent occasions where an error was made by care workers when giving medicine. We tracked what happened when these incidents occurred.

We saw that as soon as the service became aware of a medication error, a senior member of staff went to the service user's home and asked the care worker to leave. The senior worker notified family and health services in order to limit any harm to the person.

We saw that care workers were taken off all calls where administration of medicines was part of the care package. They were then performance managed and received additional supervision, training and support from Radis (Tamworth). While Radis (Tamworth) had not prevented some care workers making errors of judgement or errors in practice, we saw that they had taken appropriate action to address the mistakes made and supported the development of the care workers concerned.

We also saw that the manager had apologised to the service users and their relatives. The service users who had experienced medicine administration errors continued to receive a domiciliary care service from Radis (Tamworth).

In these instances, referrals to the local authority safeguarding team had been made by families. Tamworth Adult Care Services suspended new referrals to Radis (Tamworth) while safeguarding investigations took place. At the time of writing, three safeguarding investigations have concluded that a medication error took place in each case. We would ask the nominated person to note that should further medication errors occur, we would expect Radis (Tamworth) to notify the safeguarding team directly.

Other evidence
We did not look for other evidence in respect of the standard.

Our judgement
The provider was meeting this standard. People were protected against the risks
associated with medicines because the provider had appropriate arrangements in place to manage medicine administration.
Outcome 14: Supporting workers

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

Our judgement
The provider is compliant with Outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us
When we visited Radis, Tamworth in February 2012, we had concerns about support and training for care workers. Not all care workers were receiving supervision. The action plan produced in response to our inspection told us that improvements had been made to the training schedule.

When we visited, Radis (Tamworth) employed 104 care workers. The manager told us that care workers had attended staff meetings which included a structured discussion of person-centred reporting using daily diary reporting sheets. She had presented the information at six staff meetings held at different times so that the maximum number of care workers could attend. We saw the plan of the meeting and dated signing in sheets indicating that about 100 care workers and fieldwork supervisors had attended these sessions in March 2012.

The action plan informed us that training had been cascaded down from senior staff to the seven field supervisors on person-centred care planning; person-centred risk assessment; record keeping and report writing and effective staff monitoring and supervision. We spoke to two field supervisors who confirmed that they had attended these training events. We asked one field supervisor to tell us her understanding of person-centred planning and she gave a good account.

We saw that an electronic training programme Aims Perform had been introduced. It covered common induction standards including first aid; administration of medicines; principles of safeguarding and protection; foundation health and safety; infection control and foundation food safety. We were told that all staff had been issued with e-learning.
user-names and passwords. We saw evidence of this in the report of the March series of staff meetings. We saw that staff had been told how to access the Aims Perform website. We were told that care workers had been given deadlines for the completion of the modules. In addition we were told that Aims Perform provided specialist training through which staff could develop their skills at their own pace.

The service manager had attended a six day leadership and management course offered through the provider organisation.

The senior staff member with responsibility for training had been trained as a trainer in dementia awareness, the Staffordshire County Council safeguarding of vulnerable adults course and in medicines administration. We saw certificates for her achievements. She had delivered dementia training to two groups of care workers and we were told that a schedule was in place to ensure that every care worker received this training by September 2012.

The training matrix confirmed that 52 care workers had received dementia training during March and June 2012. The training matrix showed that all staff, with the exception of 2 staff who were on maternity leave and one on long-term sickness leave, had completed mandatory annual course in medicines administration and manual handling during 2012.

We looked at the records of supervision for care workers. We saw that spot checks were made of care worker's work with people and any issues were followed up in supervision. For example, one care worker was not wearing an apron during a visit. In supervision, this was linked back to training in health and safety and food hygiene.

We spoke to seven members of staff. They all expressed the view that Radis (Tamworth) provided what they needed to do their jobs and did what they could to ensure that staff were well-trained.

**Other evidence**
We did not look for other evidence in respect of the standard.

**Our judgement**
The provider was meeting this standard. People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.
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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What people who use the service experienced and told us
When we visited Radis Homecare in February 2012, we had some concerns about the systems in place to monitor and review services. The service responded to our concerns by producing an action plan.

We were informed that quality monitoring calls were taking place and that reports were produced at regular intervals which gave details of feedback from people who used the service. We saw records of calls made; a summary sheet and analysis of the information. The feedback generated action points.

A senior member of the staff team had been given responsibility for quality assurance. The staff member was visiting people who had expressed concerns. The registered manager showed us the plan for quality assurance visits. We looked at a record of one visit made to a person who had expressed concern about the timing of calls.

A letter had been sent to people who used the service encouraging them to contact the office about any concerns they had. The manager told us they wanted to "iron out any little issues and get the care working to people's individual needs and preferences". We saw a copy of this letter dated 6 April 2012.

The provider company Radis Community Care had carried out a quality survey. We saw the report of this survey. We were told it had been sent out to all service users.

We saw a system of spot checks was in place to ensure that care workers were
delivering care in an appropriate way. Showing respect was one of the aspects of performance that care workers were assessed on. We saw that spot checks were recorded. Information from spot checks was discussed with care workers in supervision sessions.

Staffordshire County Council have commissioned a substantial contract with Radis (Tamworth) for the delivery of care. As part of their contract monitoring they had introduced a call system which monitored the number and timing of care visits made. The care worker was required to dial into the system on arrival at a person’s home and again on leaving. They used the person’s own telephone. This enabled the council to see whether visits were made and the time and duration of the visit. The monthly reports enabled Radis (Tamworth) and the provider organisation Radis Community Care to see levels of care and which care workers were successful in getting to people on time and which ones were not. We looked at the Council’s performance report about Radis (Tamworth) for the four week period ending 23 June 2012. The total number of care visits made was 10,503. There were no missed visits, although 13% of calls were made earlier than the specified time and 8% were made late. The registered manager told us that one of their improvement aims was to increase the percentage of care workers who made their care visits within the time allowed. This was routinely addressed in supervision.

Other evidence
We did not look for other evidence in respect of the standard.

Our judgement
The provider was meeting this standard. The provider had an effective system to regularly assess and monitor the quality of service that people receive.
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
The provider is compliant with Outcome 21: Records

Our findings

What people who use the service experienced and told us
When we last inspected this service we had moderate concerns that records were not always kept securely; that care plans lacked detailed information about people's care needs and that some records contained errors.

We saw that the action plan produced after our visit had addressed these issues and had been followed through. We were told that filing was undertaken by field supervisors on a weekly basis; all documents were secured in lockable filing cabinets. We saw no files or documents lying around in the office.

A new system of documenting people's needs was introduced in March 2012. We saw that six new documents were in use:

a service-user care plan which had sections on "What I can do for myself" and "What do I need help with";
an assessment of how the service would support people's needs, for example "I need one carer to assist me with preparing my lunch";
a medication risk assessment; which included details about possible side effects of medication.
a medicines authorisation form;
a health and safety risk assessment checklist which provided a comprehensive outline of potential risks which could be tailored to individuals' circumstances; this included
details about whether cash or bank statements were visible. an outcome based service user review form.

We saw that these packs of documents provided a detailed and comprehensive account of how people viewed their own needs.

We saw that almost every member of staff had received training outlining management requirements and expectations when completing the different types of record. The action plan referred to "robust monitoring measures" to ensure procedures were being followed. We saw that field supervisors were signing that they had read records before filing them. We saw that a senior fieldwork supervisor monitored all medication records and signed these off before filing.

Other evidence
We did not look for other evidence in respect of the standard.

Our judgement
The provider was meeting this standard. People were protected from the risks of unsafe or inappropriate care and treatment.
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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

**Compliance actions:** These are actions a provider must take so that they achieve compliance with the essential standards. 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.
Information for the reader

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