Redyfne Recruitment And Staffing Limited

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Inspection report

Suite 16, Gor Ray House
758 Great Cambridge Road
Enfield
Middlesex
EN1 3PN

Tel: 07728369061

Date of inspection visit:
10 January 2019
11 January 2019
14 January 2019

Date of publication:
21 March 2019

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

This inspection took place on 10, 11 and 14 January 2019 and was announced. At the last inspection of this service on 7, 9 and 13 November 2017 we found that some aspects of risk management were not safe and there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that this had been addressed and risk assessments now provided information for staff on how to minimise risks.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults. At the time of the inspection the service was supporting 31 people.

Not everyone using Redyfne Recruitment and Staffing Limited receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe and well-led to at least good.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's personal risks were well documented. Since the last inspection, more information had been included to provide staff with guidance on how to minimise people's known personal risks.

There were no people having their medicines administered by care staff. Staff prompted people with their medicines and all staff had received medicines management training.

People received continuity of care and often had the same care staff visiting them. People and relatives told us that staff were generally on-time and stayed the correct amount of time. However, we also received feedback that people did not always receive continuity of care at weekends. We have made a recommendation regarding weekend staffing.

Staff had received training in safeguarding and understood how to recognise and report any concerns.

Staff were aware of how to ensure that people were protected against the risk of infection and had access to gloves and aprons.

Staff were recruited safely. The service completed necessary checks to ensure that staff were safe to work

with vulnerable adults.

People and relatives said that they felt safe with the care staff that visited them.

Staff received an induction when starting work and were supported through regular supervision and appraisal.

People were supported to express their views and were actively involved in making decisions about their care. Where appropriate, relatives had been involved in planning people's care, including pre-assessments prior to receiving care.

People were supported with their nutrition and hydration where this was an identified need. People were positive about the support they received with meals.

Staff were aware of how to report concerns if they noticed a change in people's health or well-being. People were referred to healthcare professionals where appropriate.

Care plans were detailed and provided enough information for staff to support people. Care plans were regularly reviewed and updated immediately if changes occurred.

People and their relatives understood how to make a complaint.

There were regular staff meetings where staff were able to discuss any issues and receive information about the service.

There were some audits completed to ensure the oversight of the service. However, whist we did not find any concerns around this, the registered manager was not always documenting that these audits were completed.

The service worked in partnership with other agencies and were aware that working with other healthcare professionals was integral to good quality of care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff were able to tell us how they could recognise abuse and knew how to report it appropriately.

There were sufficient staff to ensure people's needs were met. People experienced a continuity of care during the week.

Risks for people who used the service were identified and comprehensive risk assessments were in place to ensure known risks were minimised.

Staff were safely recruited and appropriate checks completed before staff started work.

People were protected against the risk of infection.

Is the service effective?

Good

The service was effective. Staff had on-going training to effectively carry out their role.

Staff were aware of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and how this impacted on the care they provided.

Staff were supported by induction, regular supervision and appraisals. People were supported by staff who regularly reviewed their working practices.

People's healthcare needs were monitored and referrals made when necessary to ensure wellbeing.

Where identified, people were supported to have enough to eat and drink so that their dietary needs were met.

Is the service caring?

Good

The service was caring. People were supported and staff understood individual's needs.

People were treated with respect and staff maintained privacy and dignity.

People and where appropriate, their relatives, were actively consulted and involved in planning care.

People and their relatives told us that staff were patient and kind in their interactions.

Is the service responsive?

Good

The service was responsive. People's care was person-centred and care plans were detailed.

Staff were knowledgeable about people's support needs, their interests and preferences.

People and relatives knew how to complain.

Is the service well-led?

Good

The service was well led. There was good staff morale and guidance from the management team.

There were regular staff meetings.

People and relatives were actively encouraged to provide feedback on the quality of care.

Systems were in place to ensure the quality of the service people received was assessed and monitored, including telephone monitoring and home visits.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 10 and 11 January 2019 at the Redyfne office. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure that the someone would be present to support the inspection. The inspection was carried out by one adult social care inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience supported this inspection by carrying out telephone calls to people and their relatives to gain their feedback about the service on 14 January 2019.

Before the inspection we looked at information that we had received about the service and formal notifications that the service had sent to the CQC. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe and well-led to at least good.

We used information the provider sent to us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we looked at five people's care records and risk assessments, five staff files including recruitment, supervision and training, and other documentation related to the management of the service. We spoke with the registered manager, deputy manager and the compliance officer. We also spoke with three care staff, eight people receiving care and four relatives.

Good

Is the service safe?

Our findings

We asked people and relatives if they felt safe when care staff visited them. People told us, "Oh yes, I feel safe with my carer" and "I feel safe with carers in the house." Relatives commented, "Yes, [family member] is safe with the carers and gets treated with respect" and "My partner is safe, even if in the house on their own with the carer."

At our last inspection we found that risk assessments failed to provide staff with guidance on how to minimise people's personal risks. At this inspection we found that the service had addressed this issue. The provider had introduced new detailed risk assessments that provided staff with guidance on how to minimise the risk and what actions to take if the risk occurred. Risk assessments were person-centred and detailed how the risk affected the person. Identified risks included mobility, visual impairment, diabetes, environment and the risk of developing pressure ulcers. A staff member said they felt the risk assessments were detailed, "Because it tells us what risk they might have." Each risk assessment had a section called 'outcome of assessment'. This noted what the person was able to do and what staff need to do to maintain their well-being, taking the identified risk into consideration. This enabled the service to assess and help maintain people's independence as far as possible.

All staff members that we spoke with could explain how they would keep people safe and understood how to report any concerns where they felt people were at risk of harm. A staff member said, "Its making sure they are safe at all times. Any concerns I would report to the office. If I was really concerned I would speak to independent agencies that deal with safeguarding."

The service did not currently administer people's medicines. The deputy manager told us that staff prompted people to take their medicines. Care plans clearly documented if people required prompting and how staff should do this. For example, 'Care worker to prompt [person] to take evening medication from the dosset box. The dosset is in the store cupboard opposite the kitchen sink'. A dosset is a box with compartments for morning, afternoon, tea-time and evening medicines that is usually filled by relatives. The service had a detailed medicines policy including recognised guidance on working with medicines in domiciliary care settings. All staff had received training on medicines awareness and staff that we spoke with confirmed that they did not administer medicines.

Staff files showed that staff were recruited safely and appropriate checks completed before the staff member stared work. This included references from previous employers, a criminal records check and right to work in the UK. The service also re-applied for staff members' criminal records check every three years in line with best practice.

We looked at staff rotas for the two weeks prior to the inspection. During the week each person had an assigned carer and there were rolling rotas which meant that people had the same allocated staff member. This meant that people experienced a continuity of care and were able to build a rapport with people. A staff member told us, "I like that [continuity] as well because I know what I'm going into and you can spot any changes and give accurate reports. When I have my regular clients, I know if their behaviour, eating habits

and bowel habits are the same. You know if they are down in the dumps you know what to say to them."

On weekends the deputy manager told us, "We have regular staff that do weekends as well." However, feedback received from people and their relatives was mixed. Positive comments included, "There is continuity of care most of the time", "Yes, I am pleased I get carer continuity" and "The continuity of carer is welcome." Less positive comments were, "Timekeeping can be a problem", "My morning carer is a regular, the evening one can vary and weekends can be a mix" and "I get the same carer in the morning. PM visits and weekends, it varies."

Staff were given between fifteen and thirty minutes travel time between care visits. We saw that care visits were allocated according to location so that there was less travel time for staff. Staff that we spoke with said that they had enough travel time to get to care visits and were able to spend the full amount of time with the person. Feedback from people and relatives included, "They stay as long as they are supposed to" and "The carer is very nice and will do anything for me but if late will not do full hours." We asked people and relatives if the service let them know if staff were running late, people told us, "Some call ahead if they are going to be late or delayed for any reason" and "The office phones if a different carer is coming." However, another person told us, "No notice is given if they are going to be late or when they fail to attend, I get most distressed."

We recommend that the service reviews how rotas are planned to ensure continuity of care at weekends.

Staff understood how to protect people from the risk of infection. We saw that supplies of Protective Personal Equipment (PPE) were available in the office and staff could collect them when necessary. Staff had received training in infection control and people told us that staff used PPE when conducting personal care. People said, "They do wear gloves and aprons" and "Yes, carers wear gloves and aprons."

There had been no accidents or incidents since the last inspection. Training on how to report accidents and incidents was given during staff induction. The registered manager told us, "Immediately it happens carers would give us a call to let us know and we would then look at the reasons why this happened. It would also help us put things in place to prevent it happening again but we have not had to do so yet."

We asked how the service learnt from issues that arose. The registered manger told us, "Every day is a learning curve for us. For example, there was one safeguarding around how the carer communicated with the client. We ensured that we spoke to the carer in a supervision and the staff member received a refresher in communication. We do talk about any issues in staff meetings to promote learning. You don't know if it could happen again so we talk to staff to help prevent it." Minutes of staff meetings showed that any learning points were discussed and staff were able to ask questions and share learning.

Good

Is the service effective?

Our findings

People were supported by staff that regularly reviewed their working practices and received regular training. Staff had an induction when they started working at the service. Records showed that staff had a two-day induction in the office which included training on safeguarding, manual handling and health and safety. Following this the deputy manager told us, "We then get them to shadow with another experienced person. For about three days, sometimes five days we get them to shadow with single carers and double-up carers. When they have finished their shadowing, we take them to meet the service users they are allocated to."

Records showed and staff told us that they were provided with training to enable them to carry out their role. Training was provided through an external training company and the registered manager who held a teaching qualification. Training records showed that staff had received training in areas such as the Mental Capacity Act, safeguarding, professional boundaries, record keeping, dementia awareness and risk assessments.

Staff received regular supervision. Supervision records were detailed and looked at areas such as the people being cared for and if there were any concerns, training requirements, rotas and if the staff member felt listened to by the service. Staff told us that they felt supported by the management. Staff that had been with the service for more than a year had received an annual appraisal. This looked at achievements over the past year, goals for the coming year, what staff enjoyed and what they had found challenging.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Services providing domiciliary care are exempt from the Deprivation of Liberty Safeguards (DoLS) guidelines as care is provided within the person's own home. However, domiciliary care providers can apply for a 'judicial DoLS'. This is applied for through the courts with the support of the person's local authority care team. Nobody currently using the service was subject to a judicial DoLS.

The deputy manager told us that all people using the service had capacity and were able to make decisions. We asked what the service would do if they noticed a change in a person's capacity. The deputy manager told us, "We would contact the family first and recommend that they contact social services. We have contacted the GP in that case but it wasn't dementia it was an infection. If they don't have family we will contact the GP." Care plans that we saw in the office were not signed by people. However, the registered manager told us, "We print two copies and one goes to the person's home, this copy is signed, the one in the office is not usually signed."

The service completed pre-assessments before care started. Pre-assessments helped form the basis for the care plan and covered all aspects of the person's wellbeing and care requirements. People told us that their care was discussed with them in a pre-assessment and their opinion of how they wanted their care to be delivered was listened to. The registered manager also said, "It's [information about care] from the referral, we do an assessment as well. We go through the care plan with them. They are very, very involved in

planning their care."

Where identified as a need, people were supported with light meal preparation. All staff had received training on food safety. People's care plans documented what people liked and what staff needed to do regarding food at care visits. For example, 'for breakfast prepare eggs and toast or porridge served with a hot drink' and 'make a cup of tea, prepare her a jam or ham sandwich serve with biscuits or cake and leave it beside her in the living room. [Person] will eat the sandwich later in the day'. Where people's relatives prepared food, this was also documented.

Where people required support to attend healthcare appointments this was documented in their care plans. The registered manager told us that if people needed this type of support, this was included in the care package authorised by the local authority. We saw that for these people, this was documented in their care plans and where relatives supported people with their healthcare, this was also documented. Staff that we spoke with understood how to report any concerns around changes in people's health. We asked what the service would do if people's care needs changed. The registered manager told us, "We refer to the council and explain why they need a reassessment. Could be a decrease or an increase [in hours required]. We also discuss with the service user as they have capacity." For example, we saw that one person had been referred to occupational therapy due to a decrease in their mobility.

Good

Is the service caring?

Our findings

We asked people and relatives if they felt that the staff who visited them were kind and caring. People told us, "My carers are very nice, they make me feel comfortable. I am very pleased with the care I get", "The carer is very compassionate" and "The carers are caring, good as gold," A relative commented, "We're very pleased with the care that [relative] gets."

We asked people whether they felt that care staff treated them with dignity and respect. People told us, "They are respectful of my dignity", "The girls are good and respect my dignity" and "They are mindful of my dignity." Relatives commented, "My partner gets personal care, carers are sociable and treat [partner] with respect" and "They always treat [person] in a dignified and respectful way."

Dignity and respect was regularly discussed in staff meetings. We saw that a meeting in December 2018 documented, 'Workers to ensure that they maintain dignity and respect. The worker must ensure that the clients are covered when assisted with their wash and also allowed to choose their clothes they want to wear and not decide for them as they have the capacity to do so and this must not be taken away from them'. A staff member said, "We have to respect them. You treat them the way you want to be treated, I respect what they want and what they don't want. You cannot force anyone to do anything they don't want to do." Staff that we spoke with understood how to maintain people's privacy and dignity when conducting personal care. One staff member told us, "It's things like keeping the door closed and making sure curtains are closed. Talking to them when you are helping them."

People's care plans clearly showed that people and, where appropriate, relatives were involved in planning care. People's opinions and wishes on how they wanted to receive their care were listened to when the care plans were written. We asked the deputy manager how they ensured that people and their relatives were involved in planning care. The deputy manager told us "For example, we will call the person first and ask if there is anyone they want to be there. They will usually tell us and the family member will usually have input as well." People told us, "Yes, I was involved in planning my care", "I met a lady and discussed and agreed it [the care plan]" and "My daughter was involved in planning my care." A relative said, "Yes, we were involved in planning [person's] care and the recent review."

Staff sought people's consent to provide care and understood how this impacted on people's welfare. Staff told us, "When I go in I ask them what can I do for you today? and they will tell me what they want" and "I always ask first and tell them what I am doing."

People's faith was documented in their care plans and staff were aware of how to respect people's faith. A staff member told us, "If I go into a Muslim home, there is a certain way in how they want you to prepare their food. I need to respect that."

Good

Is the service responsive?

Our findings

Care plans contained practical information on tasks that needed to be completed at each care visit as well as information on people's personal preferences. Care plans gave brief information on people's circumstances, such as their environment, medical history and family members involved in their care. Where people required personal care, care plans documented how the person wanted to receive their personal care and what staff should do. For example, a strip-wash in their bedroom or a full shower.

Staff told us that people's care plans were in people's homes and they had access to them. One staff member said, "Yes they are there, when we go in that's the first thing that we ask for. Everything is really there."

We saw that care plans were reviewed yearly. The deputy manager told us that care plans were reviewed, "Once circumstances change and reviewed every year. If someone goes to hospital and needs an increase in care package we will change the care plan. Same if care needs have decreased." People told us, "I had a review [of my care], there was no change" and "I had a review some time ago, care increased for night-time shower."

Where people required help to access the community, we saw that this had been documented in their care plan. For example, one person that received a high level of care, their care plan listed the activities they liked to do and what they enjoyed to do in the community. Staff were able to explain how they supported the person to have an active role in their interests.

The service had a complaints procedure that was given to people when they started to use the service. The registered manager told us that they had received no complaints since the last inspection. People told us, "I don't have any complaints [about my care]" and "Any concerns I phone the office to get them to resolve them." Relatives that we spoke with understood how to raise complaints and felt that the service would listen to them if they did.

The service did not routinely provide end of life care. However, the registered manager told us that since the last inspection two people had requested that the service continued to provide care alongside the palliative care team. The registered manager told us, "When they reach that stage the end of life people take-over. We have had two ladies that wanted us to stay with them when the palliative teams were working with them, which we did."

Good

Is the service well-led?

Our findings

Staff that we spoke with were positive about the registered manager and told us that they felt supported by management. Staff commented, "I love the way our agency is because we all know each other. They know me and they trust me and I can trust them" and "Oh yeah, If I need any help I get information and support. I call [the office] and they always help. I get loads of support."

There was a clear staff structure in place and staff we spoke with were aware of how to report concerns and understood the management structure of the service.

People that we spoke with were also positive about the service. Feedback included, "They've always been there, they're helpful", "Yes, I would recommend them to somebody in need of a carer" and "From my own personal experience, I would say they are well managed."

At our last inspection we found that the registered manager had not identified, through auditing, that risk assessments did not always provide adequate guidance for staff. Care plans did not document people's capacity around decision making. At this inspection we found that care plans now documented people's capacity and risk assessments provided staff with adequate guidance.

We saw that some audits around records were completed. People's daily logs which documented the care that had been given were audited. The deputy manager told us and we saw, "We randomly pick four or five people's daily logs. We check for the type of information that's there such as does it relate to the care plan, language used, if you picked up the log sheet would you know what care had been delivered. If an issue is found this is addressed. For example, one staff member was not being detailed and not stating what care had been given. The audit picked this up and the staff member was brought into the office to retrain in how to complete daily logs appropriately." The registered manager regularly audited people's care files and staff files and told us, "I go through them and if there is anything I will address it." However, whilst we did not find any issues related to care or staff files, these audits were informal and were not documented. Following the inspection, the registered manager sent us new forms where these audits could be recorded.

There was good oversight of training that staff received. Training records showed when staff had received training and when it needed to be refreshed.

The service actively sought feedback from people and relatives regarding the quality of the service they received and their satisfaction. There were also other systems in place to check the quality of care being provided. The service completed regular monitoring visits and telephone calls that looked at the quality of care people received. One person said, "On occasions we get a visit from the office." Where any issues were identified, we saw that the service documented this and addressed it.

There were records of regular staff meetings that allowed staff to discuss care needs and development of the service. Staff said that they felt comfortable raising any issues and felt that staff meetings were useful. Topics discussed included safeguarding, communication, time keeping and maintaining dignity and respect.

The service worked well with other agencies such as healthcare professionals and social services. We saw regular reviews and referrals in people's care files.