Select Support Partnerships Ltd

Peterborough Office

Inspection report

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Tel: 01733396160

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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

Peterborough Office is registered to provide personal care for people living at home. The agency provides care to adults and older people, some of whom may live with a learning disability or dementia. At the time of our visit there were 82 people who were using the services provided by the agency.

This comprehensive inspection took place on 23 August 2016 and was announced. It was carried out by one inspector.

The provider is required to have a registered manager as one of their conditions of registration. A registered manager was in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the agency. 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 were kept safe and staff were knowledgeable about reporting any incident of harm. People were looked after by enough staff to support them with their individual needs. Pre-employment checks were completed on staff before they were assessed to be suitable to look after people who used the service. People were supported to take their medicines as prescribed.

People were supported to eat and drink sufficient amounts of food and drink. They were also helped to access health care services and their individual health and nutritional needs were met.

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA 2005] and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. The provider was aware of what they were required to do should any person lack mental capacity. People's mental capacity was assessed and people were able to make decisions about their day-to-day care. Staff were trained and knowledgeable about the application of the MCA.

People were looked after by staff who were trained and supported to do their job.

People were looked after by kind staff who treated them with respect and dignity. They and their relatives were given opportunities to be involved in the setting up and review of people's individual care plans.

Care was provided based on people's individual needs and helped to reduce the risk of social isolation. There was a process in place so that people's concerns and complaints were listened to and these were acted on.

The registered manager was supported by a team of management staff and care staff. Staff were supported and managed to look after people in a safe way. Staff, people and their relatives were able to make suggestions and actions were taken as a result. Quality monitoring procedures were in place and action was

taken where improvements were identified and being required.

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.

People's individual needs were met by sufficient numbers of staff.

People were kept safe as there were recruitment systems in place which vetted prospective employees.

People's medicines were safely managed.

Is the service effective?

Good

The service was effective.

The provider was acting in accordance with the Mental Capacity Act 2005 legislation to protect people's rights.

Staff were trained and supported to enable them to meet people's individual needs.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were looked after by kind and attentive staff.

People's rights to independence, privacy and dignity were valued and respected.

People were involved and included in making decisions about how they chose to be looked after.

Is the service responsive?

Good

The service was responsive.

People's individual health and social care needs were met.

People's needs were kept under review to ensure their planned care was appropriate to their needs.

The provider had a complaints procedure in place which enabled people and their relatives to raise their concerns. These were responded to, to the satisfaction of the complainant.

Is the service well-led?

Good

The service was well-led.

People were enabled to make suggestions to improve the quality of their care.

Management systems were in place to ensure staff were aware of their roles and responsibilities in providing people with the care that they needed.

Quality assurance systems were in place which continually reviewed the quality and safety of people's care.

Peterborough Office

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 agency under the Care Act 2014.

This inspection took place on 23 August 2016 and was announced. It was carried out by one inspector. The provider was given 24 hours' notice because the location provides a domiciliary care agency and we needed to be sure that someone would be in.

Before the inspection we looked at all of the information that we had about the agency. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law.

The provider completed a provider information return (PIR) and sent this to us before the inspection. This is a form that asks the provider to give some key information about the agency, what the agency does well and improvements they plan to make.

Prior to the inspection we made contact with a local authority monitoring officer. This was to help with the planning of the inspection and to gain their views about the management of the agency.

Before the inspection we sent out 50 surveys to people and received 18 of these back. We also received three out of 50 surveys which we sent to people's relatives.

During the inspection we visited the agency's office where we spoke with the registered manager; the team manager; one senior member of care staff and three members of care staff. We also spoke with two people and four people's relatives via the telephone.

We looked at four people's care records and medicines' administration records. We also looked at records in relation to the management of staff and management of the service, including audits and minutes of meetings.

Good

Is the service safe?

Our findings

We checked and found people were kept safe because of how they were looked after. In their survey responses people told us that they felt safe from the risk of harm. Responding relatives also told us in their surveys that they felt their family member was safe from the risk of harm. People and their relatives, told us that they had no concerns about the safety of how people were looked after. They said that this was because staff treated them well. One person told us that the care staff were "lovely girls."

Members of staff told us that they had attended safeguarding training and demonstrated their knowledge about this subject. They were aware of the different types of harm and the correct actions they would take in reporting such incidents. Members of care staff also told us about the signs that people might show if they were experiencing harm. One member of care staff described an example of when they found and reported suspected neglect of a person. They told us about the action they took and said, "I told [name of registered manager] and they reported it. Social services and safeguarding [team] got involved." Another member of care staff described the physical and psychological signs that people might show if they were being harmed. They said, "If it is physical, you would see the marks of their skin. If it was emotional they become different. Such as having panic attacks."

We found that recruitment of staff protected people from unsuitable staff. The provider told us in their PIR that the recruitment process ensured that people were kept safe from unsuitable staff. The PIR read, "Safe Recruitment Practices - Potential staff are subject to interviews, which ask questions around their practice and ethics. Within this process potential staff have to explain any gaps in employment. Interviews are scored and staff have to achieve a pass mark to be considered for employment. Before starting work all employees are subject to enhanced DBS [Disclosure and Barring Service police check] checks and reference checks. Members of care staff described their recruitment experiences and told us that their required checks were all in place before they were allowed to start work. The team manager said, "We send out application forms. I read through them with [name of registered manager] to make sure it's completed accurately. I will also be looking at their [prospective staff members'] employment histories. We call them [prospective staff members] in for an interview when we ask about them about this [any gaps in employment history]. They also have to pass a written English and maths test before anything else." The team leader explained that if the prospective member of staff passed their written tests, written references and a satisfactory DBS would be obtained. This would be before the prospective member of staff was able to start work. Staff recruitment files held all the required information before the members of care staff were allowed to commence their work.

There were enough staff to look after people and meet their individual needs. People told us in their survey responses that staff arrived on time and stayed for the agreed duration of their call. During our visit people and people's relatives told us that this was the case. One person said, "It is not very often staff are late." Another person told us that, following their discharge from hospital, care staff sometimes stayed "a bit longer" to help them. One relative told us that the care staff were "punctual" and stayed the expected length of time. One member of care staff said that the agency always had enough staff. This enabled them to arrive on time and stay the allocated length of time. They also added that occasionally they would spend a bit

longer if the person wanted to talk about something that they wanted to share. Other members of care staff also told us that there was enough staff to look after people's individual needs. This included, for example, the availability of two staff members to help people with their personal care and moving and handling needs by means of a hoist. One relative said, "There is always two [care] staff to get [family member] showered."

There were arrangements in place to cover staff absences and time off to ensure that people received continuity of care. The registered manager told us that other staff would cover their colleagues' work, if needed. One person's relative told us that it was during staff absences that there would be a change of staff. However, they explained that this was well-managed. They said that their relative, who lived with dementia, received continuity of care. As a result their family member remained at ease, even with a change of staff who were unfamiliar to them.

People's individual risks were assessed and managed to keep people as safe as far as possible. This included, for instance, risks of falls and development of pressure ulcers. One person told us that members of care staff "always" ensured that they had their two walking sticks with them; otherwise they would fall without them. The senior member of staff described how people, who were at risk of pressure ulcer development, were assessed and monitored. They said, "We keep an eye on them [person]. We monitor the person's skin when we get them in a shower and we check their skin." Other risk assessments were in place for people's homes. The team manager said, "For risks we would look at the carpets; the electric [supply] and the lighting. If we found that the furniture needed moving [for moving and handling equipment] we would discuss it with the person and their relatives."

We found that members of staff ensured the security of people's homes. One member of care staff described how they obtained people's door keys from key safes. This included the use of codes that they had access to. They said, "I remember the code. I put this in. Take the key out. Close the hatch and 'scramble' the numbers." They told us that this was so, "The numbers [of the key code] are no longer visible." Therefore the risk, of any unauthorised person to gain unwanted entry to people's homes, was managed.

People were satisfied with how they were helped with taking their prescribed medicines. Most people told us that they were enabled to remain independent with this. However, when people needed care staff to help them, they told us that they were happy with how this was done. One relative also told us that they were satisfied with how their family member was helped with taking their prescribed medicine. They said, "Staff give [family member] their medicines. They lay them out for [family member] and makes sure [family member] takes them." Another relative said, "[Family member] has [prescribed medicines] patches put on [family member's] arm every day by the care staff." They added that the members of staff ensured that their family member took their medicines as prescribed. Members of care staff told us that they were trained and assessed to be competent to help people in giving their prescribed medicines. The team leader said that people's medicines administration records were checked for their accuracy and had found that these had been completed. This showed that people were helped to safely take their prescribed medicines.

Good

Is the service effective?

Our findings

We found that the provider was ensuring that people's rights were respected in line with the Mental Capacity Act 2005 [MCA]. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in registered services are called the Deprivation of Liberty Safeguards [DoLS]. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager advised us that people were assessed to make day-to-day decisions and that no person was subject to an authorised DoLS. However, they were aware of the process to follow in the event that this situation might change. This included contacting the local authority for advice.

Members of staff were trained in the application of the MCA and demonstrated their knowledge about this piece of legislation. The team manager said, "Basically every person has to have mental capacity to make decisions and they also have choices. Even if they don't understand they have the right to be at the meeting to support them in decision making." They added that such meetings would be held in the person's 'best interest'. They also gave examples of how staff enabled people to make choices in relation to the clothes that they wanted to wear and what they wanted to eat. The senior member of care staff was also able to demonstrate their knowledge about the MCA and said, "Everyone has [mental] capacity unless deemed otherwise." However, not all of the staff were able to demonstrate such a level of knowledge of the MCA. The registered manager assured us that they would take action to refresh members of care staffs' knowledge about this. Nevertheless, members of care staff were able to tell us about how they offered choices to people to make day-to-day decisions about how they wanted to be looked after. This included, for example, using effective strategies to encourage people to take their medicines as prescribed. One member of care staff described how they would help a person to calm down. This was so that they took their medicines which they had previously been reluctant to take. People's mental capacity assessments were maintained and held in their individual care records.

The provider had systems in place to make sure that staff were trained and supported so that they had the competence and confidence to do their job well. Our survey respondents wrote that they felt staff were trained and competent to do their job. During our visit relatives also told us that the same. This included, for example, when members of care staff had helped their family member with their mobility needs by means of a hoist. Another relative also told us that staff were competent in being able to understand their family member's complex communication needs.

Members of care staff told us that they attended training, which also involved induction training. Induction

training included learning about the provider's policies and procedures and undertaking health and safety training. The induction training also included new staff members 'shadowing' more experienced staff members. One member of care staff explained about their 'shadowing' experience. They said, "They [management team] put me with a more experienced carer. I watched how they did personal care. Medicines. How to communicate with people. It helped me a lot to learn new things. I am now confident to work on my own." On-going training included the management of people's medicines; emergency first aid and completion of the nationally recognised Care Certificate training programme. Staff were also provided with career development opportunities. These included undertaking National Vocational Qualifications [NVQ] in care. At the time of our visit there were 35 members of care staff working for the agency. The senior member of care staff, who was also an NVQ assessor, told us that, "Six care staff have NVQ level 2. Two are doing NVQ level 3 and we have signed up for two more [care staff] to take their NVQ level 2."

People were looked after by staff who were supported to do their job. Information contained in the provider's PIR told us that there was a system in place to supervise members of staff. Members of care staff told us that they felt supported and also received one-to-one supervision. This was the time when they were able to discuss work-related matters and their training and development needs were identified. One member of care staff said, "I had one [one-to-one supervision] recently. We discussed about people [using the agency] and if they were happy with me. My training and development needs were also discussed." The team manager also told us that 'spot checks' were carried out to assess the standard and quality of members of care staffs' work. They said that feedback would take place during the members of care staffs' one-to-one supervision. This was so that any areas of improvements were discussed and actions to be taken. This included, for example, providing re-fresher training.

People were supported to maintain their nutritional health. One person told us how the care staff made and prepare their meals three times a day and always had a drink available throughout the day. One relative told us that care staff helped their family member to eat and drink. They told us that this had improved their family member's nutritional intake. They added, "They [care staff] make sure [family member] now eats 'proper' food."

The agency provides care to people with a range of cultural backgrounds which influenced what they chose to eat. Members of care staff, who were also from similar cultural backgrounds, demonstrated their knowledge about the different types of cultural diets. This included for example, English foods and foods for people of the Islamic and various Indian faiths.

People were independent or had help from their relatives to attend health care appointments. However, if this assistance was not available, members of care staff helped. One member of care staff said that they helped a person attend a GP and hospital appointment. One relative told us that, "On occasion they [care staff] have needed to ring [family member's] GP." One relative told us about the action that one member of care staff took when their family member had a fall. They said, "They did the right thing by getting [family member] into hospital." One person's relative wrote to the provider to thank them about how their family member was looked after. The compliment letter read, "[Name of member of care staff] found [family member] very unwell. They saved [family member's] life."

The care staff helped people to remain at home and promote their sense of well-being. One person told us that they had regained their level of independence following their discharge from hospital. They attributed this to the quality of the care that the agency provided. Another person said that the care enabled them to stay at home. They said, "[Being at home] is better than being in a care home." This showed us that people's individual health and well-being needs were met.

Good

Is the service caring?

Our findings

People's rights to independence, privacy and dignity were valued and respected. In their surveys people told us that the care helped them remain as independent as possible. People also told us that staff, who were caring, valued and respected their dignity and privacy. People's relatives also told us in their surveys that they agreed with this statement.

During our visit people and relatives had positive comments about members of care staff. One person said, "At the moment I have two carers [staff members] and they are excellent. They do what I ask." One relative said, "It is always the same two [members of care staff]. They have got to know [family member] and [family member] has got to know them." Another relative said, "The staff are always talking with [family member]. They communicate well with [family member. And they don't rush [family member]. The three girls [members of care staff] are brilliant. [Family member] loves them to bits. They [family member] trusts them completely." In their compliment letter a relative wrote, "We will be eternally grateful for the brilliant work you do, you have developed a wonderful team of individuals [staff] who care about the people they help." One member of care staff said, "I'm happy as I am working with older people. Talking to them. Listening and not rushing them."

People's rights to independence were valued. One person described how their independence with making food and drinks had improved since their hospital discharge. Another person told us that they were independent with the management of their medicines. One member of care staff described how they supported people to be independent with their personal care. They said, "If they can wash their face, we let them do it."

People, including their relatives, told us in their surveys that they were involved in setting up their planned care. During our visit we also found how the care supported people's relatives or their main carers. One relative said, "The care package is very, very good. It is five times a day and it was what we wanted." Another relative said, "I feel happy that staff are going in [to look after family member]. It is a great comfort."

However, one person told us in their survey, "The main problem is a language barrier as all [care workers] are ethnic minority races, who, although kind, don't fully understand or speak English." Because of this less than positive comment we explored this further. During our visit one relative said, "There is no problem with [members of care staffs'] accents." The registered manager explained the action they took when a concern was raised about one member of staff's accent. They told us that this was reviewed and that other caring qualities of the staff member matched the person who they were looking after. They said, "We found that the member of care staff had a bit of broad accent. Because of the demeanour and empathy of the member of [care] staff we felt that we did not need to change [them]. They were looking after an older person and these were the attributes which matched the person." They assured us that there were no further concerns about the member of staff's communication abilities. The provider wrote in their PIR that they aimed to match people with staff. The PIR read, "Where possible we match service users [people who use the service] cultural needs with staff who are from a similar cultural/gender background." People told us that they were introduced to staff before they provided them with their care. The team manager confirmed this and said, "I

take [care] staff out to meet people before they begin the care and to build up a rapport."

Staff valued people's rights to make choices and decisions about their care. People told us in their surveys that they were enabled to make decisions about their care. Care records provided evidence that people's choice of how they wanted to be looked after was valued. One relative told us that their female family member "always" had female members of care staff to provide them with personal care. This was their and their family member's preference. The senior member of care staff described how they supported a person's choice of washing with running water or by a shower, as this was their cultural preference.

Both the registered and team managers advised us that, although they had contact with advocacy services, no person was using this support. Advocacy services are organisations that have staff working for them who are independent and support people to make and communicate their views and wishes.

Good

Is the service responsive?

Our findings

People's needs were assessed to ensure the agency was able to meet their needs. Local authority assessments and subsequent support plans were in place. Some of the people were independent in paying for their care. As a result the management team would carry out their assessment. One relative said, "The [registered] manager and [name of team manager] met me at [family member's] bungalow, which I thought was nice. We discussed [family member's] needs." They told us that the planned care of two call visits per day was meeting their family member's needs. All of the responding relatives told us in their surveys that they were satisfied with how their family members' care was provided to meet their needs.

People were helped to engage in social activities to reduce the risk of social isolation and promote their sense of well-being. One relative told us that their family member was taken out in their wheelchair. They said, "It does [family member] good to get out in the fresh air a couple of times a week." They also told us that when the weather was good, their family member was helped to sit out in their garden. It was here where they were visited by friends and neighbours. The team manager described how they supported two people to go swimming. One member of care staff told us that they helped a person to go to a coffee shop. They said that this was run by people from the same cultural background as that of the person who they were supporting.

People's care records and risk assessments were kept under review during 'spot checks'. This review process complemented the formal reviews carried out by local authorities who had responsibility for the assessment and funding of people's care. Staff had access to detailed local authority care plans. However, the provider's care records were brief in content and lacked information about people's life histories. Nevertheless, members of care staff demonstrated their knowledge about how people liked to be looked after. This included taking into account people's cultural dietary preferences and personal care choices. Furthermore, due to consistency of members of care staff, they told us that this had helped them get to know people as individuals. One member of care staff said, "Everybody is different regarding their diets."

People were listened to if they wished to raise a concern or complaint. People's relatives told us in their surveys that they were satisfied with how the provider responded to their concerns and complaints. However, some of the people told us in the surveys that they were not fully satisfied with how their complaints were managed. We checked this at the inspection and found that people were satisfied with how their concerns were listened to. One relative said, "I tell [name of team manager] if there are any issues. The communication is good." Another relative said, "There was one missed call. I rang the agency and they sorted it out in half an hour." The registered manager said, "Even at the introduction to the service [agency] we talk to the service user [person using the agency] or relative. We tell them that you can talk to us and we will talk to you. Communication is vital." The team manager gave an example of the action taken in response to a person's concern. They explained that due to "a personality clash" between one person and a member of care staff, changes were made to the team of staff. People told us that they had written information about how to raise a concern or complaint. The information contained details of outside agencies, which include the CQC, should any person wish to contact these independent organisations.

The provider told us in their PIR that there was one complaint received. From this complaint, remedial and improvement actions would be taken. These were recorded in the PIR which read, "Complaints procedure to be written in different languages. Advocacy - To use independent Advocacy Services from culturally diverse organisation."

Good

Is the service well-led?

Our findings

There was a registered manager in post at the time we visited the agency. They were supported by one team manager and a team of care staff. People, including people's relatives, knew who to contact in the office, which included the registered manager, if they needed to talk to someone.

People had positive comments to make about the management of the service. One person told us that they were, "Very happy with the care provision. The registered manager and team manager are very understanding and very helpful and act on what is requested." Another person told us, "I am very happy with manager and agency." A third person said, "I am very happy with my carers and the [registered] manager, who always listens and acts on requests made. The team manager will always make sure to phone and ask how I am, and if I am happy with the service."

We found that the provider operated an open culture in the management of the service. The local contracts monitoring officer had a positive comment to say about the registered manager. They said, "[Name of registered manager] has worked quite well with us with any concerns and they will look into it for us." They gave examples of the remedial action that was taken to improve, for instance, the recruitment of staff.

Members of staff were aware of the provider's whistle-blowing policy and knew what they would do if they needed to use it. One member of care staff described how they had previously used the whistle-blowing policy. They said, "Whistle-blowing is when you feel something is not right. If someone was at risk. I would report it to the office and they would report it to the local authority or police. There is a whistle-blowing policy and they [provider] have to operate the confidential code [of practice]." All of the staff members advised us that they would have no reservation in following the whistle-blowing policy, should they have concerns about people's safety. This showed that the provider operated a culture which enabled staff to openly report concerns and protect people from the risk of harm.

The provider demonstrated how they operated an inclusive style of in the management of the agency and this was by enabling staff to complete surveys. The results of the surveys for 2015 showed that staff were satisfied with how they were being managed. The registered manager told us that, as there were positive results of the staff survey, no remedial actions were needed. However, they said that there was some learning taken from this and this would be to improve the quality of questions posed in future staff surveys.

Staff were also provided with another opportunity to make suggestions and comments during staff meetings. Minutes of these meetings - which were well-attended - demonstrated that staff were able to contribute to the agenda items. The senior member of care staff described the staff meetings to be "informative." The team meeting minutes also showed that members of staff were reminded of their roles and responsibilities. These included, for example, being punctual and staying the duration of the call visits. Staff were also reminded that they were responsible in attending and completing their Care Certificate training programme.

People and their relatives told us that they, too, were able to share their views about the standard and

quality of the service provided. This included, for instance, via telephone communication from the team manager. The team manager said, "Every month I print out people's names and I call them by telephone and will find out how things are [with their care]."

The provider sent their PIR in when we requested it which showed that they were aware of their legal responsibilities as a registered person. The information detailed in the PIR showed that there was a quality assurance programme in place which aimed to continually improve the standard and quality of people's care. The registered manager was aware of their legal responsibilities' in submitting required CQC notifications. However, there was no reportable incident or event that warranted such notifications to be submitted.

'Spot checks' were carried out as part of the quality assurance system. One member of care staff said, "The 'spot checks' are unannounced. They [management team] check for punctuality. How we are getting on with the person. How we communicate." The team manager told us that the 'spot checks' also provided people with opportunities to share their views about how they were being looked after. Records of staff 'spot checks' were maintained and these demonstrated that where there were deficiencies, the team manager discussed the issues during a one-to-one supervision with the responsible member of care staff. This included, for instance, the lack of punctuality and should staff members not stay the expected duration of the call visit. The registered manager advised us that there was a staff disciplinary procedure in place and this would be used if needed. This was to make sure that people were receiving the care in accordance with their planned care.

Another part of the provider's quality assurance system included monthly reports. The registered manager told us that they compiled these reports, which included complaints, staff training, accidents and 'good news' stories. The reports were seen and reviewed by the provider based at their head office. Their reviews would result in identification of any remedial actions to be taken by the management staff of Peterborough Office. The registered and team managers advised us that there were no outstanding remedial actions to be taken at the time we visited.