Care Quality Commission

Southampton City Council

City Care First Support - Sembal House

Inspection report

Sembal House
Handel Terrace
Southampton
Hampshire
SO15 2FH
Tel: 02380443044
Website: www.southampton.gov.uk

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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?	Requires improvement

Overall summary

The inspection took place on 19 and 24 November 2015 and was announced. We gave 48 hours notice of the inspection because the location provides a domiciliary care service and we needed to be sure that records would be available.

City Care First Support service is the local authority's rehabilitation and reablement service. It is registered to provide personal care for adults, and supports people in their own homes for up to a six week period. The number of people using the service fluctuates but tends to be between 160 and 180 at any given time. The aim of the service is to give people the opportunity to relearn or regain some of the skills for daily living that may have been lost as a result of illness, accident or disability.

Summary of findings

There was a registered manager at the service. 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 said they felt safe with the staff who visited them. People were supported by suitable staff because the provider followed robust recruitment procedures and ensured satisfactory pre-employment checks were completed. The provider had policies and procedures in place designed to protect people from abuse and staff had completed training with regard to safeguarding adults. Risks were identified and managed so that people were protected but able to improve their physical abilities. The team was managed and rostered on duty in a way which meant people were supported by the same staff. People were supported with their prescribed medicines by staff who were trained to do so.

The aim of the service was to enable people to continue living at home. The staff therefore supported people in a way which promoted their independence and increased their mobility and personal care abilities. Staff were supported in their role through induction, training and supervision. However, staff were not always able to access refresher training within the timeframe set by the provider.

Staff supported some people to eat and drink as part of their task plan. Staff also liaised with healthcare professionals, seeking advice when necessary.

Staff formed positive caring relationships with people they supported and spoke about people in a caring way. People made every day decisions such as how they liked to be supported and what they liked to wear. Staff knew how to respect people's privacy and dignity when supporting them with personal care.

The service provided care and support to meet individual needs. Staff visited people to discuss their preferences with them and to undertake an assessment of their needs. There was a complaints procedure in place and people felt able to complain. Complaints were investigated and people received a response.

The management team promoted a positive culture that was open, inclusive and empowering. Staff were clear that the culture was one of team work which included the management. The ethos of the service was to provide the best quality care and the registered manager ensured they sought views from people using the service as well as staff.

Prior to the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service is safe.

Staff had received training in safeguarding adults and were aware of how to use safeguarding procedures.

People had risk assessments in place to ensure every day risks were identified and minimised where possible.

Staff had been recruited following satisfactory pre-employment checks and there were enough staff to meet people's needs.

People received their medicines as prescribed.

Good

Is the service effective?
The service is not always effective.

Staff had access to training but some training had not been updated within the provider's own timescale.

Staff were supported in their role through induction, relevant training and supervision.

People were supported with their meals and accessing health care professional when necessary.

Good

Is the service caring?
The service is caring.

Staff cared about the people they supported and enjoyed spending time with them.

Staff respected people's privacy and dignity as well as their right to make decisions and choices.

Good

Is the service responsive?
The service is responsive.

People's assessed needs were met by staff who understood the ethos of the service. People were encouraged to be independent and improve their mobility and ability to look after their own personal care.

There was a complaints procedure in place and complaints were recorded and investigated.

Good

Is the service well-led?
The service is not always well led.

Requires improvement

Summary of findings

The provider did not complete the Provider Information Return which we requested.

The service promoted a positive culture that was open, inclusive and empowering.

The ethos of the service was to provide the best quality care and the registered manager aimed to achieve this by seeking views from people using the service and staff.

City Care First Support - Sembal House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection took place on 19 and 24 November 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that records would be available.

The inspection was carried out by one Inspector. Before the inspection, we reviewed the information we held about the service. This included notifications about important events which the service has to send us by law. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

During the inspection we spoke with five people, four relatives, six staff and the registered manager. We looked at a range of records including four task plans and two staff recruitment records.

Good

Is the service safe?

Our findings

People said they felt safe with the staff who visited them. One relative said, "Yes, [staff] understand [my relative] is isolated, they use the key pad and lock all the doors." Another relative confirmed the person felt safe with staff as they had "never mentioned anything untoward."

The provider had policies and procedures in place designed to protect people from abuse. Staff had completed training with regard to safeguarding adults and gave us examples of the different types of abuse and what they would do if they suspected or witnessed abuse. Staff were aware of the safeguarding category of "self neglect", which is a new category and showed that staff were up to date. The registered manager was aware of how to refer concerns to the local authority safeguarding team and had done so appropriately.

Individual risks were identified and action was taken to minimise risks, whilst still enabling people to be as independent as possible. Staff said co-ordinators visited people at home and completed a risk assessment, which included issues such as rugs on the floor or broken steps. Co-ordinators told staff about the risk assessments and a copy was left in the person's home for them to read. Staff confirmed risk assessments were up to date. As people's needs improved or otherwise changed, they reported this to the office. Risk assessments were then updated and a staff member would take the new risk assessment out to the person's home. One staff member said "There's no point if a change at lunchtime is not put in place by tea time!"

Staffing levels were based on a fixed number of budgeted hours and the number of care packages provided was agreed according to the number of staff available. The staff were organised into three teams which worked on a rolling rota. The teams either worked early, late or had a day off. There was also a team of staff who visited people during the night, if their night time needs were being assessed. This meant people were supported consistently by the same staff team. Co-ordinators were based in the office and their shifts started before the staff came on duty which gave them time to ensure calls were covered in the event of staff being unable to work that day at short notice.

Whilst people were supported by consistent staff teams, they were not guaranteed a visit at the same time every day. The service's statement of purpose stated the time arrangements as being within certain timeframes, such as 7-11am. The co-ordinators also discussed times when they first visited people. Some people were prioritised within the time frames, according to their needs, such as needing medicines at certain times. Two people mentioned that the staff visited them at different times; however, they understood the reasons why. Staff were aware that sometimes people expected them at the same time each day. However, they thought there were benefits to supporting people in the way they did. One said "We're not timed, if we have spare time we can go back and spend time to chat [if people want that]" and "If you take longer to support a person, you report back so they can change the calls." Staff felt the co-ordinators trusted their judgement with this.

The provider had a recruitment procedure in place which included seeking references and completing checks through the Disclosure and Barring Service (DBS) before employing new staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We found the checks had been undertaken before new staff started work.

People received support with their medicines by staff who were trained to do so. Some staff had an additional level of training which enabled them to create and amend Medication Administration Records (MAR). People often left hospital with bags of medicines which needed to be sorted and listed on the MAR. Records were completed to show medicines had been given to people appropriately and as prescribed.

Staff were clear about what tasks they could do with regard to medicines as well as the limitations. If people declined to take their medicines staff appreciated this was their choice and would contact the office and GP. Staff received training during induction; one staff member said the course had included one to one training with a pharmacist. Senior staff completed competency tests which were completed annually thereafter. Staff were aware that some medicines required specific spacing, such as four hourly. This was usually accommodated within the timings of the visits, but if occasionally, this was not the case, staff would contact the office and return later to administer the medicines.

Errors were sometimes made with regard to medicines but staff felt able to report them to the office. Advice was

Good

Is the service safe?

sought from health care professional to ensure people were safe. The error was recorded, an investigation was undertaken and staff went in to the office to complete refresher training and a competency assessment.

Good

Is the service effective?

Our findings

Staff were supported in their role through induction, training and supervision. Training covered what the service considered to be mandatory such as moving and handling and infection control, as well as other relevant topics. A computer system highlighted when staff needed to refresh this training. However, staff were not always able to access the training within the timeframe considered appropriate by the provider. The registered manager found that where courses were available, there were not enough dates on offer as the service could not send large numbers of staff on the same day which had led to delays in staff attending refresher training.

Staff were knowledgeable and positive about the training they received to support them in their role. Comments included "We are constantly training…[they are] always on top of training…anything you want to do they nominate you", "The supervisor asks you about training" and "I love training…when I go I find out something I didn't know." Staff told us how during the training they had walked using crutches and wore a blindfold to try to understand how people they supported might be feeling. Staff identified if they had a specific training need. A co-ordinator told us that during supervision a staff member said they were working with someone who had diabetes and they would like to know more about it. Therefore the co-ordinator put their name down for a training course.

The aim of the service was to enable people to continue living at home. The staff therefore supported people in a way which promoted their independence and increased their mobility and ability to care for themselves. The service ensured people received effective care and this was evidenced by the number of people whose abilities improved enough for them to stay at home rather than in hospital or residential care. One person said "staff know what they are doing; they're good at what they do."

Newly appointed staff had completed the Skills for Care Common Standards induction, which is a set of standards staff working in adult social care need to meet before they can safely work unsupervised. The Skills for Care induction has been superceded by the Care Certificate which will now be used for new staff. Staff also undertook two days of training specific to their role of reablement, which informed staff about the ethos of the service and how to work with people to encourage them to be independent. Staff were recruited on a six month probation period to ensure staff were suited to the job and that they received enough support.

Supervision and appraisal are processes which offer support, assurances and learning to help staff development. Staff received support through regular supervision sessions which were either formal face to face meetings or direct observations of their practice. Staff had not yet received their annual appraisal of their work which was overdue but dates had been booked in for everyone.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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. The registered manager was aware of the MCA and the impact this had on the way they supported people. Some people already had mental capacity assessments in place when the service started to support them. If people were assessed as having less capacity for some decision making, they could still make every day decisions such as what to wear or eat that day. The majority of staff had received training in understanding the MCA, either through the induction process or by attending specific training. If people's capacity appeared to change whilst staff were working with them, staff would contact the person's care manager and GP for further advice. Staff were aware about the need for people to make choices and take positive risks. An example of this was supporting someone to walk upstairs so they could remain at home.

Staff supported some people to eat and drink as part of their task (care) plan. Staff supported some people to prepare their own meals, such as breakfast and heat up main meals in the microwave. If the person needed more support, staff would prepare the meals for them. Staff were aware that people living with dementia sometimes needed a different level of support to ensure they ate well. One staff member said "sometimes you just need to sit with people and keep them company". Food and fluid charts were sometimes completed if a person was not eating and drinking well and healthcare advice was sought.

Good

Is the service effective?

Staff contacted healthcare professionals when necessary or as part of the person's assessment. Staff told us they could contact GPs, community nurses, occupational therapists and physiotherapists and could ring the ambulance service in an emergency.

Good

Is the service caring?

Our findings

Staff formed positive caring relationships with people they supported. One person said "I'm very independent, but after the first couple of days I was enjoying their company. I love them all." Another person said "I would like to thank them very much, they were very caring." Comments from relatives included, "I think they cared, they're all friendly and jolly, my [relative] enjoyed chatting with them" and "I met [a staff member], they had been talking about my [relative's] past, their career and what they watched on television." Staff spoke to us about how they supported people and through these conversations we saw that staff cared about people and sometimes 'went the extra mile'. Staff had the time to demonstrate a caring attitude when they visited them. One staff member said "I sit and chat with people in my free time."

People were involved in making decisions about their care and support. During the assessment, their needs were discussed and they could express their preferences. Staff asked people how they would like to be supported. One person said "They ask how I want to change clothes…it was so easily done."

The registered manager said if people wanted family members to be present when discussing their support needs, staff involved them and arranged meetings at a time to suit them. If an advocate was already allocated to the person they were also involved as necessary. Advocacy services could be accessed if needed. The services of translators had also been used to aid communication with people whose first language was not English.

Staff explained how they respected people's dignity when they supported them with personal care. This included ensuring doors and curtains were closed and covering them with a towel. Staff were mindful that the service was about reablement. This meant staff encouraged people to undertake aspects of their personal care themselves, even if they could not attend to everything. People were able to decline personal care if they wished and this was recorded by staff. However, if this happened frequently, staff followed up through liaison with care managers and doctors.

Good

Is the service responsive?

Our findings

People were positive about the service. Comments included, "[staff] are very good, all the ladies are nice, they offer to help, I look forward to seeing them", "they are so helpful, I ask them and they help me" and "I haven't had one I haven't liked…they are brilliant." A relative said their parent was "very happy" and confirmed staff ensured they had their meals and medicines, saying "the staff offer to do a lot."

The service provided care and support to meet individual needs. Some people had left hospital and needed staff to encourage and reable them with their personal care needs or with their mobility. Others were being assessed to see what permanent care and support they might need. The service was designed to support people for up to six weeks at which point the person no longer needed any support or support was provided by other providers of care. The registered manager said the service continued to provide support after six weeks until the new service started, such as a care agency or residential care.

After a referral was made to the service, co-ordinators visited people at home or in hospital to assess their needs. People's views were sought, along with their relatives, if they wanted them to be involved. The task (care) plan was therefore created around their needs, preferences and choices. The service employed male and female staff and this was discussed with people during the assessment. If people had a preference for male or female staff this was highlighted on the computer system so the co-ordinators could allocate staff accordingly. People could also voice their opinion if they did not want a specific staff member to visit them again. One staff member said "we cater to our service users." We saw that task plans were signed by people where possible. A check list was on file which showed staff had explained the task plan, risk assessments and the timing of visits and that consent to care had been gained. Records showed people received care and support according to their assessed needs.

People and their relatives knew how to complain if they were unhappy with the service provided. The provider had a complaints procedure in place and co-ordinators made people aware of it during their first visit. The procedure was explained verbally and written information was left in their homes.

Staff were clear that people could complain if they wished and knew what to do if someone complained to them. The registered manager kept a record of the complaints received. We found complaints were investigated and complainants received a letter, apologising where necessary and explaining the conclusions of the investigation. Minor complaints could be dealt with over the telephone but more serious complaints would result in a visit to the person to discuss their concerns. We saw that the service also kept a file containing letters and cards, thanking staff for the service people had received. There were 34 records of thanks for 2015 up to November when we inspected.

Requires improvement

Is the service well-led?

Our findings

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgement regarding how well led the service was. The PIR was sent to the provider's nominated individual but they had stopped working for the provider and their role was not being covered and their emails not read. The provider did not take prompt action to ensure an application was sent to us to register a new person in the role of nominated individual.

The management team promoted a positive culture that was open, inclusive and empowering. Staff were clear that the culture was one of team work which included the management. Comments from staff included "We all work as a team; the [management] are approachable. We are all trained to feel confident to do our role. I'm confident that if I can't do something and ask for help I'll get it" and "the [management] update us, if and when they can, about changes." Staff also felt they worked as a "real team and management do their upmost to support us."

Staff were clear about their job roles and were encouraged to be involved with how the service was provided. One staff member said, "we have team meetings, we can give feedback and get feedback back… it is a good service, I enjoy working here."

Staff spoke about the registered manager in a positive way. Comments included "They [management team] are supportive, sound, approachable" and "If you have a problem, you can air it, go to the manager, I'll say if I don't agree and she'll listen".

There was a view from the management team that "If you give more responsibility, people will take it on board." Staff were "encouraged to make decisions on the information they have at the time. There is a no blame culture." The registered manager said this "trickled down from the top" and they had seen improvements in how the staff team worked since promoting this way of working. They also said "Employees are our best resource; they can ask us for support... I wouldn't ask someone to do something I wouldn't do myself."

The ethos of the service was to provide the best quality care and the registered manager ensured they sought views from people using the service as well as staff. When people were coming to the end of the period of time allocated to them for support they were asked to complete a questionnaire. The results were collated for a three month period and analysed, before being shown to staff. We saw the results of recent questionnaires were positive. The registered manager had started to send questionnaires to care managers and this process was still being developed.

Staff were also encouraged to be involved in how the service was run. The management team had an "open door" policy which meant staff could speak with them easily. Team meetings were used to ask staff if they had any "good ideas". The management team identified that a particular staff related form was not being completed by some staff and asked them about this. Staff told management they did not know how to fill the forms in. Therefore they added prompts to the form which meant staff now completed the forms effectively. This format was then used in other local authority services.

The registered manager was developing a system of audit to monitor specific areas of record keeping. Five areas had been identified to be audited on a rolling basis. Safeguarding concerns and staff supervisions had already been audited with no actions identified. The remaining three areas were around complaints, supervision and medicine errors.

There was a system of peer audit in place where a manager from another local authority service would audit the quality of the service. The most recent audit had suggested two improvements to record keeping systems and the registered manager had implemented these.

The registered manager ensured notifications were sent to us. A notification is information about important events which the provider is required to tell us about by law.