The Regard Partnership Limited

Domiciliary Care Agency Surrey

Inspection report

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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

This inspection took place on 19, 22 and 23 August 2016 and was announced.

Domiciliary Care Agency Surrey provides a supported living service for people with learning disabilities and or autism in transition from residential college, foster care or the family home. The service has four supported living schemes. We visited two: Middle Gordon Road and Gordon Avenue.

Middle Gordon Road is a supported living scheme with 24 hour staff support and accommodates up to seven people.

Gordon Avenue is a supported living scheme with 24 hour staff support and accommodates up to six people.

The service did not have a registered manager. 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 and associated Regulations about how the service is run.

The registered manager of Domiciliary Care Agency Surrey had resigned a few weeks prior to this inspection and we had been notified. A new manager had been appointed and had only been in post for a few weeks. A locality manager told us they will be submitting an application to CQC for the registration of the new manager.

People receiving care were safe. Their feedback about the safety of the service described it as consistently good.

Their risks had been assessed and well managed. There were policies and procedures for managing risk and staff understood and followed them to protect people.

There were appropriate procedures in place to help ensure people were protected from all forms of abuse. Staff had received training on how to identify abuse and understood procedures for safeguarding people.

Staff managed medicines safely. The service stored medicines correctly, disposed of them safely and kept accurate records.

People were protected from the risks associated with the recruitment of new staff. The service followed safe recruitment practices.

People were safe because staffing levels were assessed and monitored to ensure they were sufficient to meet people's identified needs at all times.

People's feedback about the effectiveness of the service described it as good. We saw that people experienced positive outcomes regarding their health. Staff knew their routine health needs and preferences and kept them under review. Appropriate referrals were made to other health and social care services.

The service ensured that the needs of people were met by staff who had the right competencies, knowledge, qualifications, skills, experience, attitudes and behaviours.

Staff understood and had a good working knowledge of the key requirements of the Mental Capacity Act 2005. They put these into practice effectively, and ensured people's human and legal rights were respected.

People said that the food and mealtimes were consistently good and spoke positively about the menu and the quality of food provided.

Staff understood how to support people with dignity. The relationships between staff and people receiving support demonstrated dignity and respect at all times.

People received personalised care, treatment and support. They were involved in identifying their needs, choices and preferences and how these were met.

There was an effective quality assurance system in place. The management and staff team were proactive in seeking out ways to improve.

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.

The service protected people from avoidable harm and potential abuse.

There were policies and procedures for managing risk and staff understood and followed them to protect people.

Appropriate recruitment and selection processes were carried out to make sure only suitable staff were employed.

Staff managed medicines safely. The service stored medicines correctly, disposed of them safely and kept accurate records.

Is the service effective?

Good

The service was effective.

Staff had the right competencies, knowledge, qualifications, skills, experience, attitudes and behaviours.

Staff received induction, training and supervision to support them in their roles.

People had access to healthcare services when they needed them. The service manager and staff were proactive in referring to health care professionals.

Staff understood how to apply the Mental Capacity Act 2005(MCA) to make sure people were not restricted unnecessarily.

Is the service caring?

Good

The service was caring.

Staff told us how they ensured people's rights to privacy and dignity were maintained while supporting them.

People were positive about the caring attitude of the staff.

People spent time with their key workers. This helped staff develop meaningful relationships and increase their knowledge of people's likes and preferences.

Is the service responsive?

Good

The service was responsive.

People received personalised care which had been discussed and planned with them, including their relatives where necessary.

People were given choices and supported to take part in activities.

People knew how to complain and felt that they were able to raise any concerns and they would be listened to.

Is the service well-led?

Good

The service was well-led.

People and their relatives are regularly involved with the service in a meaningful way, helping to drive continuous improvement.

Staff felt supported by the registered manager who they described as approachable.

There were procedures in place to monitor the quality of the service. Any deficiencies found were quickly rectified.

Domiciliary Care Agency Surrey

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 was carried out by one inspector.

Before the inspection we looked at information we held about the service. This information included notifications sent to the Care Quality Commission [CQC] and all other contact that we had with the home since the previous inspection. We also looked at the Provider Information Return [PIR] which the registered manager had completed before the inspection. The PIR 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.

During the inspection we spoke with the locality manager, newly appointed manager, two home managers, and six staff. We also spoke with six people who were receiving care.

We also reviewed a variety of records which related to people's individual care and the running of the supported living homes. These records included; care files of people living in the homes, staff records, audits, and policies and procedures that related to the management of the service

Good

Is the service safe?

Our findings

People told us they felt safe using the service and they were treated well. Referring to one of the supported living schemes, one relative told us, "143 Gordon is safe. We are very pleased our relative is safe." A person using the service told us, "I like it here. I get on with everyone in the house. Staff make sure we are all safe."

People who used the service were protected from the risk of harm and abuse. Staff were able to speak about areas of risk knowledgeably and they correctly explained what they would do if they witnessed or suspected that abuse had taken place. Staff knew and were able to tell us about signs of abuse, including relevant reporting procedures, such as reporting concerns to their manager, shift leader or where appropriate, the local authority or Care Quality Commission (CQC). Safeguarding notifications had been sent to CQC as required and social care professionals told us that the staff were open and communicative about any safeguarding concerns or events associated with the service. Records confirmed staff had received training in safeguarding. Safeguarding information was displayed in the offices of two supported living schemes we visited.

People were encouraged to raise concerns about their safety in regular house meetings and in individual 'keyworker meetings'. This ensured that everyone regardless of their needs or the strengths of their voices was supported to have their say. For instance, the 'key worker meeting guidance' asked staff to enquire about people's safety. This included prompt response questions such as, 'Do you stay safe in the community? How can we support you with this?' One person told us, "We have a weekly house meeting and we talk about many things and raise concerns we may have."

Risk assessments for the environments where people lived had been drawn up and were regularly reviewed with the changing needs of the people who lived at the supported living schemes in mind. All incidents were recorded and an outcome based plan was included to minimise the risk of future occurrence. Each person had a personal emergency evacuation plan (PEEP) in their plan of care. This gave guidance to staff to ensure people's safety was protected during the evacuation of the building in the event of fire or other emergency. An up to date fire safety risk assessment and emergency plan was in place. We saw evidence fire drills took place regularly.

People were protected from the recruitment of unsuitable staff. Recruitment records contained the relevant checks. These checks included a Disclosure and Barring Service (DBS) check, evidence of identity, right to work in the country, and a minimum of two references to ensure that staff were suitable and not barred from working with people who used the service. This helped to ensure people employed were of good character and had been assessed as suitable to work with people.

Staffing levels were flexible so that if people needed extra support there were staff available for this. We saw examples where staffing levels were adjusted beyond the usual ratio in response to people's needs. During the day of our visit we saw people participating in activities accompanied by staff. There were sufficient staff to support people and to stay with them so that people could enjoy their preferred activities.

People's medicines were handled safely and according to the service's policy and procedure. Staff had received up to date training in handling medicines and were able to tell us about safe practice. They also understood what certain medicines were prescribed for, the side effects they may have on people and the importance of keeping medicines under review. The service had a system for auditing medicines. This was carried out by senior staff. There were no gaps in the medicines administration charts examined. This showed people received their medicines as prescribed.

Good

Is the service effective?

Our findings

People receiving care confirmed staff had the right skills and knowledge needed for their role. One person told us, "Staff showed me how to cook and I can now cook on my own." Another person said, "I prepare my own food. Sometimes I need help from staff and staff are very nice to me." A third a person told us, "[This member of staff] is my keyworker. He contacts my dad for me. After this placement, my keyworker is helping me to find another place."

The service ensured that the needs of people were met by staff who had the right competencies, knowledge, qualifications, skills, experience, attitudes and behaviours. Staff were supported to complete national qualifications in health and social care. There was evidence they were supported and encouraged to complete a variety of training including, person centred care planning, challenging behaviour and physical intervention, schizophrenia awareness, epilepsy awareness, health and safety, moving and handling, food hygiene, safeguarding, medication administration, respect and dignity, and communication skills.

Staff had a thorough induction that gave them the skills and confidence to carry out their role and responsibilities effectively so that people had their needs met and experienced a good quality of life. Staff had completed the Care Certificate standards modules either as a refresher for existing staff or as part of induction for new staff. These are nationally recognised standards of care which care staff needed to meet before they can safely work unsupervised. The home managers told us staff were observed and assessed in practice to ensure they met essential standards of care, which we confirmed from records. Staff were also complimentary regarding the quality of the training. A training matrix showed training had been put together to specific months in the year and that refresher training had also been booked.

Newly recruited staff were not permitted to work alone unsupervised until they and the managers were confident they could do so. The service allocated staff effectively focussing on their skills, experience and compatibility with the person they were supporting. The new manager and the locality manager told us induction included a period of shadowing experienced staff to ensure they were competent and confident before supporting people. All this meant that people were supported by staff who had the skills to meet their needs and ensure their safety.

The service had a proactive approach to staff members' learning and development. Their needs were identified to make sure that they could effectively meet people's needs and preferences. Staff were supported by annual appraisals where goals were discussed and a plan of development was agreed. Most plans included professional development such as gaining qualifications in health and social care. Some staff we spoke with were studying for either a level two or level three. A staff member told us, "I was supported to complete my NVQ (National Vocational Qualification) Level 3."

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. The MCA 2005 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 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). In other settings such as supported living schemes authorisation should be sought from the Court of Protection.

Staff understood and had a good working knowledge of the key requirements of the MCA. They put these into practice effectively, and ensured people's human and legal rights were respected. The service had up to date policies and procedures in relation to the MCA and consent. The managers and staff were knowledgeable about the requirements of the MCA and issues relating to consent. Care records showed people's mental capacity had been assessed in regards to making specific decisions about their daily lifestyles.

The service engaged proactively with health and social care agencies and had acted on their recommendations and guidance to meet people's needs. We saw that appropriate referrals were made, including to behavioural specialists, psychiatrists, speech and language therapist, occupational therapists and GPs for relevant assessments. There was evidence people experienced positive outcomes regarding their health and mental well-being as a result. For example, some people in the respective supported schemes, displayed behaviours which challenged the service but this was shown to have decreased since they started receiving relevant interventions.

The service took preventative action at the right time to keep people in good or the best of health. Each person had a Health Action Plan, which set out their health needs. This, in conjunction with annual health checks ensured potential health problems or unmet needs were identified in early stages. People's needs had been identified in their support plans and staff were pro-active in making sure these were well met.

People said the food and mealtimes were good and spoke positively about the quality of food they ate. They felt actively involved in this aspect of the service and able to give feedback on a regular basis. For example, one person told us, "I do cook my own food but staff help me when I am not feeling well." Another person said, "The food here is good. I do my own weekly shopping and staff help me to buy healthy food." We saw that people were supported to maintain a balanced diet. In some examples we saw that a diet and nutrition support plan had been implemented to ensure some people were supported with their nutritional needs.

Good

Is the service caring?

Our findings

People who used the service were consistently positive about the caring attitude of the staff. One person receiving care told us, "Staff ask me how I am feeling." Another person told us, "Staff help me when I am not feeling well."

We spent time with people in the communal areas of the respective supported living schemes we visited and observed there was a relaxed and caring atmosphere. People were comfortable and happy around staff. They exchanged good-humoured chatter, which kept everyone involved laughing. One person told us, "I get on with staff. I have a laugh and a giggle. Staff always share jokes with me." Another person said, "I like to socialise. I can have a laugh with staff."

The relationships between staff and people receiving support demonstrated dignity and respect at all times. People were well-groomed and dressed comfortably. Staff spoke with people in a respectful way, giving people time to understand and respond. We asked staff how they ensured they respected people when they undertook personal care and they told us they make sure people were clothed as much as possible, and that curtains were drawn so nobody could see from the outside. We observed throughout the inspection staff knocked on bedroom doors to check if they could enter.

People were proactively supported to express their views and staff were skilled at giving people the information and explanations they needed and the time to make decisions. For example, key worker meetings were held every four to six weeks. The meetings gave the service the opportunity to establish people's satisfaction with their care. From this information key workers could take action if any issues were expressed. For instance, action was taken to improve activities, menu and the environment on the basis of people's feedback.

Staff communicated effectively with every person using the service, no matter how complex their needs. They knew people's individual communication skills. As a result they had developed a range of ways to make sure people were able to say how they felt about the support they received. We saw many examples of communication tools and systems, each tailored to the specific needs of the person, including those associated with symbols and pictures. We could see that this improved people's independence and participation as they were able to have a say regardless of their relative complex needs.

People were supported to maintain the relationships they wanted to have with friends, family and others important to them. Relatives of people and records showed people had contact with family members. Some people received regular visits from family members and some used IT technologies to have video contact with their relatives. One person told us, "Staff support me to speak with my [family] via [social media]." Another person said, "I meet with my friends. One of them is coming to my birthday party." Each person had a key worker. The role of the key worker involved giving the person reassurance to feel safe and cared for and building relationships with their families and relatives. We saw evidence of regular 'keyworker meetings'.

People were fully involved in planning their care plans. Reviews were centred on them and were held in the way they chose for themselves. Where people were unable to express their views family members or advocates were involved in decision making processes to ensure people's views were expressed wherever possible. People were able to invite who they wished to the meeting, where it was held and what the topics would be discussed.

Good

Is the service responsive?

Our findings

People using the service we spoke with told us staff were responsive. They told us the care delivered was focused on their individual needs and preferences. One person told us, "I go to staff and [raise concerns] and they do something about it." Another person said, "I get all the support that I need."

People received personalised care, treatment and support. Their care, treatment and support was set out in a written plan that described what staff needed to do to make sure personalised care was provided. For instance, besides people's involvement in their initial assessments, care planning and reviews, the 'keyworker meeting' provided an opportunity to establish people's needs and preferences. 'Keyworker meeting guidance provided examples of questions to help keyworkers to discuss particular topics with people. Questions included, 'what makes you angry or upset'; 'how can staff help you to manage your problems; 'do you feel able to safely medicate'; 'would you like to do more in the community and how can we support this'. From this information, we saw staff took action if any issues were expressed. One person's short term goals developed after a keyworker meeting included, participating in rock climbing, trampolining, skiing, and visiting a relative's grave. This person told us, "Staff are great. They support me to visit my mother's grave." This showed people were involved in identifying their needs, choices and preferences and how these were met.

Care, treatment and support plans were seen as fundamental to providing good person centred-care. They were thorough and reflect people's needs, choices and preferences. People's changing care needs were identified promptly, and were regularly reviewed with the involvement of the person and put into practice. We saw many examples of this. For instance, one person's review, which was also attended by a relative, identified what the person wanted to achieve during the course of the next six months and we saw the goals were continually reviewed to check progress. In another example, a care review had identified one person required the support of a counsellor and we saw this was arranged. This person told us, "I am feeling low and down. Staff have arranged for someone to come and speak with me."

People had a choice about who provided their personal care. They were empowered to make choices and have as much control and independence as possible. One person told us, "I am quite independent. I cook on my own." Another person said, "I self-medicate. I need support to re-order the next lot. That is the next step." A further person told us, "I have learnt to travel by myself. I visit my [relative] who lives [abroad]." Where people had activities outside of their homes such as for shopping, attending healthcare appointments or going to a day centre and they needed support to continue with these activities, appropriate support was provided according to their preferences. One person told us, "Staff support me to go on the bus to the activity centre."

The service protected people from the risks of social isolation and loneliness. The service recognised the importance of social contact and companionship. The service enabled people to carry out person-centred activities and encouraged them to maintain hobbies and interests. For example, one person had completed three courses through ELearning in preparation for a new job. This person was also active in the local community and also attended the local charity that provided recreational activities to people with learning

disabilities. This showed staff made sure people were able to keep relationships that mattered to them, such as family, community and other social links.

There were many ways for people to feed back their experience of the care they received and raise any issues or concerns they may have. A formal complaints procedure was available to all parties. One person told us, "I go to staff and complain and they do something about it." At the time of this inspection, the service had not received any complaints. However, the managers were clear that concerns and complaints would always be taken seriously, explored thoroughly and responded to in good time.

Good

Is the service well-led?

Our findings

People's feedback about the way the service was led described it as good. One person told us, "The manager cares about us." Another person said, "I like it here. The manager comes and asks how I am feeling." Staff told us they were supported to do their work. They told us the managers listened to them and took their views on board.

The registered manager of Domiciliary Care Agency Surrey had resigned a few weeks prior to this inspection for an opportunity outside the organisation and we had been notified. A new manager had been appointed and had only been in post for a few weeks. A locality manager told us they will be submitting an application to CQC for the registration of the new manager.

The service has a clear vision and set of values that included honesty, involvement, compassion, dignity, independence, respect, equality and safety. These were understood by staff and put into practice. We observed this throughout the inspection. For example, the organisation had facilitated a group of people receiving care to draft a charter. The name of the group was RISE, which is an acronym for Respect, Independence, Speech and Equality. The charter was aimed at making involvement better for people who used the service. The group had developed and agreed six rules for the charter including, 'We must be at the centre of our care planning and any decisions made about our lives'; 'We want to live our lives independently' and 'We want to be more involved in our community'. The new manager told us this was being rolled out across the organisation from September 2016. She told us they are scheduling local, regional and national forums of involvement.

Staff had the confidence to question practice and to report concerns about the care offered by colleagues, carers and other professionals. When this happened they were supported and their concerns were thoroughly investigated. A staff satisfaction survey that was carried out in June 2016 showed staff were either satisfied or extremely satisfied in some key areas, including opportunities for training, team work, expectations from managers and satisfaction with the job. There was an action plan to address some other key areas, including a pay review, involving service users more in recruitment and more opportunities to visit other services.

Staff understood their role. They appreciated what was expected of them, and were happy in their work. They told us managers were available to support staff. One staff member told us, "The manager is approachable." Another staff said, "The manager is very good. She keeps us updated and informed. I have just completed my NVQ level two and she has been very supportive." The service held regular monthly team meetings. This enabled staff to get together to share views, information and gain support. We noted from the minutes that staff had the opportunity to raise any issues and we saw action was taken to improve the quality of the service.

Quality assurance arrangements were in place and the need to provide a quality service was fundamental and understood by all staff. Processes were in place to enable managers to account for actions, behaviours and the performance of staff. Staff received supervision and appraisals. We read the analysis of a quality

audit that was carried out in August 2016. This looked at number of areas, including medicines management, staff recruitment, safeguarding procedures, staffing, 'service user satisfaction surveys' and people's rights. The audit was conducted in line with CQC five domains of safe, effective, caring, responsive and well-led. This encouraged the service to consider the service's performance across all five areas. We saw that actions plans were drawn up to address any identified points for improvement.

The organisation had national and regional structures and they ensured they kept an overview of risk and safety to inform their business planning and strategic oversight to provide corporate direction to the organisation. There was a regional health and safety committee, which met quarterly to review all the incidents reported in the organisation. We read minutes of the committee that met in June 2016, which discussed, incidents/accidents, RIDDORS, near misses, slips/trips/falls, staff Injuries and medication.