Mrs Carol Barkwell

Lyndridge Care and Support

Inspection Report

Unit 1B
North Road Industrial Estate
Okehampton
Devon
EX20 1BQ
Tel: 01837 54782
Website: www.lyndridgecare.co.uk

Date of inspection visit: 1-2 May 2014
Date of publication: 27/08/2014

Contents

Summary of findings

Overall summary

Lyndridge Care and Support is a domiciliary care service providing personal care to people in their own homes. At the time of the inspection 150 people were receiving personal care and support from the agency. The majority were older people but there were also people with mental health needs and learning disabilities. The amount of support people received with their personal care varied from a few hours a day to 24 hour support.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law like the provider.

People using the service told us they were happy with the support they received. They told us support staff were: "Very friendly" and helped them remain independent. People said they would complain if they needed to and were confident any complaints would be dealt with. One person told us: "I do know about the complaints procedure, I'm good at that. But I haven't had to use it."

Care plans were detailed and reviewed regularly. Care plans for people with a learning disability used pictures to supplement the text to help people understand their plans. People told us they were involved in developing their plans and were aware staff used them regularly. One person told us: "They have a book with everything that happens to me written in it. They write every day."

We looked at risk assessments contained within care plans. We found those for older people who used the service did not give staff clear guidance on how to minimise risks for individuals. The operations manager told us they were planning to develop the way in which risk assessments were written in order to make them more personalised and relevant.

Staff told us they enjoyed their jobs and were well supported by their line managers. We saw they received training which was appropriate to their roles.

There was a well-defined management structure in place and staff told us they were clear about the lines of accountability. People who used the service and staff told us they found management effective and efficient. One person said: "The manager definitely runs the service well. It is very efficient and I get all the care that I need."

Quality monitoring was carried out regularly in order to assess the standard of care provided and implement any required changes. This helped ensure staff from the agency were able to respond quickly to people's changing needs.

We found the staff understood the requirements of the Mental Capacity Act 2005.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Nobody we spoke with had any concerns about the quality of care they received from Lyndridge Care and Support. People using the service told us they felt safe.

Lyndridge Care and Support had effective safeguarding policies and procedures in place. Staff described to us the procedure for reporting allegations of abuse. This meant people were safeguarded against the risk of abuse.

There was an effective system in place to document accidents and incidents and learn from them so they were less likely to happen again.

Documents we saw showed that mental capacity assessments and best interests meetings had taken place as required by the Mental Capacity Act (2005). Staff we spoke with demonstrated a good understanding of the requirements of the legislation and what they should do should a person lack the capacity to make a decision.

Staff worked with the same people which meant there was consistency of care. There were enough staff to support people well.

Lyndridge Care and Support had a robust recruitment process in place. This meant people were protected from the risk of being supported by staff who were not suitable or appropriately qualified to carry out their responsibilities.

Risk assessments were in place and were reviewed regularly. We found the quality of risk assessments was not consistent across the different groups of people using the service. This meant staff might not have clear guidance on how to minimise risk for individuals.

Are services effective?

Staff ensured people's needs and preferences regarding their care and support were met. Staff recognised the importance of people being involved in decisions about the way in which their care and support was delivered.

Care plans were detailed and informative. They gave staff clear guidance as to how best to support people. Communication in staff teams was good which meant staff were always fully informed of any changes in people's care needs.

Information was presented in a way which enabled people to take part in the care planning process.

Summary of findings

Lyndridge Care and Support had an induction process in place to help ensure people were supported by staff who had the knowledge and skills necessary to carry out their roles and responsibilities.

People were supported by staff teams to help give continuity of care. Staff had regular supervision. Most of the staff teams had regular staff meetings but this was not consistent across the agency.

Staff told us they had enough training to do their jobs effectively. Training was provided in areas such as moving and handling and medication. Where a need for more specialised training was identified, such as autism, Lyndridge Care and Support were able to organise this.

Where necessary, the amount people ate and drank was monitored. However, we saw in one person's care file that although the amount the person drank was recorded, it was not clear how much they should be drinking.

Are services caring?

People who were in receipt of personal care told us they were happy with the service provided. A family member told us they often visited their relative and had no concerns about staff. They commented; "They're all very nice."

Staff worked with people to maintain their privacy and dignity. People told us they were treated with respect.

Staff spoke knowledgeably and with fondness about the people they supported. We saw people were involved in decisions regarding their personal care.

Are services responsive to people's needs?

Quality assurance questionnaires were circulated to people who used the service, relatives and staff to give them an opportunity to air their views about a range of subjects. Lyndridge Care and Support used the results to identify where improvements could be made to people's experience of support.

We saw people were supported to express their views and be involved in decisions about their care and support. People were given information they needed, at the time they needed it, and in a format that helped them understand it.

Mental capacity assessments were carried out as required. Where people were deemed to lack capacity decisions were taken in people's best interests following the appropriate processes.

Summary of findings

People's individual needs and preferences were recorded in the care files. This meant staff had information which enabled them to support people in the way they wanted.

People were protected from social isolation and encouraged to be part of the local community.

Lyndridge Care and Support had a complaints procedure in place. Complaints were responded to appropriately and promptly.

Are services well-led?

There was a positive and open working atmosphere within staff teams. Staff told us they felt well supported by their managers.

There were sufficient numbers of staff to meet people's needs.

Spot checks were carried out regularly to ensure staff were providing people with personal care that met their needs.

Emergency plans were in place to protect people from risks associated with foreseeable adverse events.

Summary of findings

What people who use the service and those that matter to them say

We spoke with 18 people who were receiving personal care from the service. They told us they were happy with the service they received. Comments included: “It’s been good. I started off not very good, now I am flourishing. The support and care brings me forward.” And “I have a delightful feel of the place. The staff are so good.”

We spoke with five relatives following our visit. One told us: “She likes it very much and gets on with the staff better than me.”

Everyone we spoke with said they felt there were enough staff to meet their needs and they knew them well. One person who used the service said: “We do get the same carers. Same ones at night and the same ones in the day. I know them well.”

Lyndridge Care and Support

Detailed findings

Background to this inspection

We visited Lyndridge Care and Support on 1 and 2 May 2014. 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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1. The inspection team consisted of a lead inspector and a second inspector. Following the inspection visit an Expert by Experience carried out telephone interviews with 16 people who used the service or their relatives. The Expert had experience of caring for a person with a learning disability and had trained as an advocate in mental health and mental capacity. They also had experience of dementia, both personally, and as an advocate.

We spent time in the office looking at records, which included people's care records, and records relating to the management of the agency. We visited two homes of people who received care and support from the agency.

Lyndridge Care and Support were last inspected 11 November 2013. There were no concerns found at that inspection.

Before our inspection we reviewed the information we held about the home. We examined previous inspection reports, information given to us by the agency, and notifications received by the Care Quality Commission. During the inspection visit we reviewed three care plans, four staff files, a selection of the agency's policies and procedures and staff training records.

In total we spoke with 18 people who were using the service and five relatives. We also spoke with a health care professional who was involved in the care of someone who used the service, 15 members of staff and the owner.

Are services safe?

Our findings

People told us they felt safe when they were being supported by staff. Comments included: “I do feel safe in all aspects. I've never had that feeling (that things are wrong).” and “Yes, it’s very safe. I couldn’t be anywhere better.” A relative told us: “Yes she’s safe, I do feel this. It’s taken a load off my shoulders. It’s incredible; this is my mum’s home. I’m welcome at all times.”

It is important staff have access to guidance about safeguarding to help them identify abuse when it occurs and respond appropriately. We asked to see the agency’s safeguarding and whistle blowing policies. The policies were comprehensive and up to date. This meant staff were able to access relevant and recent information regarding the safeguarding processes in place to protect people.

Staff told us they had received updated safeguarding training and we confirmed this from the agency’s records. We asked members of staff what they would do if they suspected abuse was taking place. They described to us the correct sequence of actions. They also outlined the different types of abuse. All said they would have no hesitation in reporting abuse and were confident management would act on their concerns but, if not, they knew where to go outside of the organisation to report any concerns.

People’s safety was protected because there was an effective system in place to manage accidents and incidents and learn from them so they were less likely to happen again. We saw accidents and incidents were recorded and analysed quarterly in order to identify any trends. The documentation showed that management took steps to learn from such events and put measures in place which meant they were less likely to happen again. For example we saw cases where, following incidents, safeguarding referrals had been made, food and fluid charts introduced and outside professionals brought in to give additional support.

We found that people were protected because the staff understood the requirements of the Mental Capacity Act 2005. Documents showed that mental capacity assessments and best interest meetings had taken place when decisions needed to be taken on behalf of someone who was deemed to lack the mental capacity to make the decisions themselves. A member of staff we spoke with told us when they had first been required to follow this procedure they had been supported by their line manager in order to ensure they understood and followed the process correctly. They said this had helped them feel confident about putting principles into practice which they had previously only had theoretical knowledge about.

We discussed the requirements of the Mental Capacity Act with the operations manager who told us they worked according to the principles of the legislation. Staff we spoke with were able to speak knowledgeably about the processes associated with the Act. We saw from the agency’s training records staff had received training in this area. We spoke with the training manager who told us refresher training for all staff was ongoing. We confirmed this from looking at the time table of planned training.

A recent change extended the definition of deprivation of liberty with implications for people being supported in their own home. We discussed this with the operations manager who was able to demonstrate an understanding and knowledge of the legislation. At the time of the inspection there were no Court of Protection applications in place for anyone using the service to restrict their freedom in order to keep them safe.

We looked at people’s care records. Whilst visiting the office we saw the care files for two older people who used the service. The records contained risk assessments which covered a wide range of areas. For example use of equipment, mobility and falls. The risk assessments we saw were generalised and had not been personalised to take into account people’s individual needs. This meant there was a risk staff would not have clear guidance as to how to support individuals and lessen any identified risks. We discussed this with the operations manager who told us they were planning to review the way in which they did their risk assessments in the near future. We also looked at the care files for someone using the service who had a learning disability and found the risk assessments were much more detailed and personalised to reflect the person’s specific needs and keep them safe.

People were kept safe as staffing levels were sufficient to meet people’s needs. People we spoke with said they there were enough staff on duty at any time to meet the needs of people using the service. One person said: “Yes, there are enough staff. I see them every five minutes and there’s lots of help. You usually have one person, or two or three if there are any issues.” People who used the service told us

Are services safe?

they knew the staff team supporting them well and liked them. At one person's home we visited we looked at the rotas for the previous week and saw staffing levels were consistent. On the day of the inspection visit one member of staff at this person's home was off sick. We were told, and we saw from the rota, the shift had been covered. The team manager told us they were usually able to cover sickness from within the staff team.

We spoke with the operations manager who told us there were dedicated staff teams assigned to work with people. This meant training could be targeted for care workers to ensure it was relevant and appropriate to the people they were supporting. This was especially important because of the varying needs of the people using the service. In addition the agency employed staff who were familiar with the care needs of a wider range of people known as 'floaters'. They were able to cover shifts in emergencies or when the regular staff were on leave. There was also a small number of bank staff available. This is staff who are flexible in the amount of hours they work and can be called on when necessary. This demonstrated the agency had sufficient staff, with the appropriate experience and skills, to meet people's needs at all times.

The risks of abuse for people was minimised because there was a safe and robust recruitment system in place. We looked at five staff files and saw they contained photographic identification, evidence of disclosure and barring service (DBS) checks, previously known as Criminal Records Bureau checks, references, including at least one from a previous employer, application forms, interview notes and copies of job offers. We saw that, where a reference had been given which was not satisfactory, the agency had asked for a further two references to ensure the person was suitable for the position.

Are services effective?

(for example, treatment is effective)

Our findings

Staff ensured people's needs and preferences regarding their care and support were met. Staff told us it was important that people were involved in their care planning and day to day choices. The operations manager commented: "It's all about knowing that person; it's about that personal relationship."

We looked at three care plans, two for older people and one for a person with a learning disability. We saw they were detailed and contained a great deal of information. We saw people had signed their care plans. This indicated people had been involved with the planning of their care and agreed to it. People and their relatives told us they had been involved in developing care plans and keeping them updated. One relative told us: "The manager talks to me about the care plan. In the last six months more information has been put in about her being helped to bed, helped to get up and get dressed." We saw care plans were reviewed regularly. This ensured staff had access to the most recent information regarding people's care needs so they were able to adapt the care and support they offered accordingly.

Staff had the knowledge to meet people's needs and choices at all times because communication within staff teams was good. For example, at one person's home that we visited, staff told us there were verbal handovers when staff shifts changed. These happened twice daily and lasted up to half an hour. This meant the incoming staff team were fully informed of any incidents or changing needs which might affect how personal care would be most appropriately delivered. Staff we spoke with were all positive about how information was shared. One commented: I can't fault my manager, we're always talking."

We saw, where people had limited literacy skills, care records contained pictures, photographs and symbols alongside the text. This meant people could be supported to better understand the contents of their care files. One care file we saw was supplemented by a "Person Centred Plan". Person centred planning is an approach to planning for the future which ensures the individual is fully involved in the process. It identifies what is important to the person and values the input of people that matter to them. The "Person Centred Plan" contained information about the person's likes and dislikes, how best to communicate with them and who should be involved in future planning and decisions. The information was detailed, personalised, and presented using pictures and simple language.

Systems were in place to ensure people were supported by staff who had the knowledge and skills necessary to carry out their roles and responsibilities. We saw from the records that newly appointed staff received an induction when they commenced employment that followed Common Induction Standards (CIS). The CIS are national standards to support staff working in adult social care to safely work unsupervised. The induction process also included a period of shadowing more experienced staff prior to working alone. We spoke with a member of staff who had recently started work with the agency. They confirmed this procedure had been followed. They told us the induction had been extensive and had made them feel confident about their ability to carry out their role competently.

Supervision enables staff to receive support and guidance about their work and discuss any on-going issues and training needs. We saw minutes of supervision records that showed these were an opportunity to discuss any issues or problems the staff member might have and any training requirements as well as check on their knowledge of the agency's various policies and procedures. Staff told us, and we saw from the records, supervisions were held regularly.

We looked at records for staff meetings and spoke with care staff. We found some of the staff teams held staff meetings on a regular basis, usually every two months. However, this was not consistent across the organisation. One of the staff team's records showed there had not been a staff meeting for eleven months and another for five months. It is important staff teams are given opportunities to share information, ideas and concerns at regular intervals. We discussed this with the operations manager who told us they would address this at the next managers meeting which was due to be held the following week. We spoke with staff who had not had a staff meeting for some time. They told us that, due to the small size of the team, communication amongst them was good and on-going. This meant staff were able to share relevant information about people's changing health needs promptly.

Staff told us they felt they had enough training to do their jobs effectively. We saw, from the agency's records, people had received training in areas such as moving and

Are services effective?

(for example, treatment is effective)

handling, medicines, food hygiene and nutrition and diet. In addition the agency provided training in areas specific to the needs of the people they were supporting, for example autism and dementia. We saw the training records for five of the staff teams. Most of the training was up to date, however we saw in one of the staff teams only four out of fourteen staff had up to date epilepsy training. We saw some people had epilepsy and therefore staff may not have had the skills to effectively meet their needs. We discussed this with the training manager who told us they were aware of the situation and people had either been booked onto training or were on the list to do so urgently. The operations manager assured us people with epilepsy would always be cared for by staff who had received the relevant training. One member of staff told us they were always given training to meet the needs of the people they supported. They told us they were going to start supporting a person who had Parkinson's Disease and had been booked on a course the following month to learn more about that particular condition.

We saw, in one person's care records, that the amount they drank was being monitored. We saw the amount of fluid they were drinking was recorded throughout the day. However, there was no indication on the charts as to how much the person should be receiving and the amount was not totalled at the end of the day. We did see a hand written note within the care plan which stated fluid intake was to be limited to 1.5 litres per day. However as this information was not attached to the monitoring charts there was a risk care staff would overlook the information meaning the person may not receive appropriate care to meet their assessed needs. For example they may have been given too much to drink because staff were not aware of the limit. Furthermore, because the amounts were not totalled there was an additional risk this would not be noticed. We discussed this with the operations manager and registered provider who updated the care plan accordingly.

Are services caring?

Our findings

We spoke with 18 people who received personal care. They told us they were happy with their support. One person we spoke with told us: “We're all well-looked after. There are four of us and it is like a family atmosphere.”

People said their staff teams were helpful and helped them maintain their independence. One person told us that prior to receiving a service from the agency they had started to “become incapacitated” but now were, “coming on in leaps and bounds.” A staff member said “We encourage people to continue to do things. It’s about their choices.”

People told us staff worked with them in a way which maintained their privacy and dignity. Comments included: “They're all very nice. I get help with the shower. There's definitely dignity and privacy. They're all very kind”, “They're very careful with respecting you. There's no invasion of privacy. They don't even discuss confidential details” and “Privacy and dignity here is about knocking on doors, closing curtains when dressing ... all the right things.”

Staff we spoke with demonstrated a fondness and affection for the people they were supporting. Comments included: “He’s good company.” And “It’s all about knowing the person. It’s that personal relationship.”

We spoke with a health care professional who commented that one of the managers they had worked with had, “...a fantastic rapport with the clients. Their work is exemplary and I’ve seen similar work from the grass roots workers.”

People told us they knew the staff who supported them well and they were aware of their care needs and how they preferred to be supported. People told us: “I get the same carers and they know what I like. “ And: “If I wasn't very well, (a named staff member) is such an excellent carer. She always notices if you're not up to scratch.” This showed us that people using the service had a sense that their needs were important and respected.

We visited people in their homes and observed staff and people who used the service talking together and involving people in their care. We noted staff were respectful in their attitude to people and conversations were friendly and relaxed. One person commented; “We all get on well.” We saw people were involved in decisions about their care and staff sought consent prior to giving personal care. For example we saw one person being asked if they wanted help with some personal care.

One person showed us around their home. We observed they were confident and relaxed with staff. We saw they demonstrated a sense of ownership about the home and took pride in showing us the shared living areas whilst respecting the private spaces of their housemates. They told us: “I love it here.”

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Lyndridge Care and Support had asked people who used the service, relatives and staff to complete a quality assurance questionnaire. This was in the form of an 'outcome star' where people rated statements on a scale of 1 (cause for concern) to 5 (as good as it can be). Statements included 'Helping people stay as well as they can be' and 'Supporting people to look after themselves'. The questionnaire results had been analysed and a report produced for each home in order to highlight any issues that may have required action. We saw the results and these were largely positive. For example one person using the service had written: 'Very satisfied with my day to day life'. A relative had reported: 'Excellent at treating my relative with dignity and respect'. Where concerns had been raised or suggestions made we saw actions had been taken.

We saw people were supported to express their views and be involved in decisions about their care and support. People were given information about the service when they first started using the service. We were told that, where it was deemed appropriate, easy read documents were developed for people such as communication passports and health passports. Easy read is a way of presenting information using pictures, photographs and/or symbols alongside simple text. It can be a good starting point for personalised support. Tools such as communication passports and health passports contain specific information in respect of an area of a person's life which the person or their supporters can use to tell others in a simple and understandable way what their needs are. It can be a quick way of presenting information about a person.

The operations manager told us people with a learning disability who used the service were provided with easy read tenancy guides and easy read information pertaining to the Mental Capacity Act 2005. This demonstrated the agency were pro-active in providing a range of easy read information which could be more easily understood by individuals or used by care staff to help people understand complex information. Quality Assurance tools such as questionnaires and surveys could also be provided in this format where it was appropriate. We visited someone at their home and saw in their care file, pictures were included within the contract of care to aid understanding.

Another care plan, for someone who had a learning disability, was presented pictorially and used plain English. This meant care staff would be more easily able to support the individual to understand about their care.

We saw one care plan had been signed by the person when it was first developed but had not been signed at subsequent reviews. We discussed this with the operations manager who told us the person concerned had been assessed as lacking capacity and were no longer able to understand the contents of the care plan. We saw, in the files, documentation to support this assessment. We were told that the agency had approached a local advocacy group and were in the process of identifying independent support for the person. This demonstrated Lyndridge Care and Support were proactive in ensuring that, where people lacked capacity to consent to their care, arrangements were put in place to protect the person.

People were supported to maintain routines which were important to them. The care plans we looked at were individualised and took into account information regarding the person's interests and preferences as well as their health care needs. For example we saw people's preferred name was recorded. One care plan recorded: "I would like a cup of tea at 8.00am. I like to go back to sleep after my cup of tea until about 9.00am."

People's wishes and preferences were sought and recorded. We saw care files contained information on how people wanted to be supported with personal care and to what extent.

We saw the agency's complaints policy and procedure. We saw from the records people's concerns and complaints were responded to appropriately and in line with the policy. For example where a complaint had been made, there had been involvement from professionals outside the organisation, and changes made to avoid a reoccurrence. We saw people's care files contained information on how to complain and a complaints form.

We asked people if they would know how to make a complaint if necessary. People said they had not had to but were confident about how they would do this and that it would be dealt with appropriately. People said they had opportunity to raise issues or concerns. One person said: "The nice thing about this place is that if you have a beef about anything you can discuss it."

Are services well-led?

Our findings

We found the working atmosphere within staff teams was positive and open. We spoke with 13 care staff. Everyone told us they felt well supported by their managers, were able to raise concerns or ideas and had opportunity to do this. One member of staff commented: "My manager's absolutely brilliant, she'll get in there and sort it out." Staff told us they had plenty of opportunity to raise any issues with their managers and felt confident to do so. One staff member told us: "There's always somebody to help."

People who used the service and relatives were positive about the management of the organisation. One relative commented: "I really believe in what they do. Their philosophy is second to none. I worked in the health service and from a professional and personal side I can't fault it."

Lyndridge Care and Support had a managerial structure consisting of several levels of management. We asked staff members if they were clear about the levels of accountability and responsibility and they all responded positively. One said: "I know who to go to for what I need." Most of the staff we spoke with and an outside professional said the registered provider was, "hands on" and "approachable". One team manager told us "Her mobile number is available at the top of every contact list, she is available." However one staff member said: "I don't know if I would be allowed to speak to her." Some members of staff expressed a strong sense of loyalty and commitment to the teams they worked in and the people they worked with. However, there was less of a sense of belonging to the larger organisation. One comment was: "I feel part of my team, not particularly Lyndridge. It's very big."

At the time of the inspection we were told the agency was fully staffed. People we spoke with said there were enough staff on duty to meet their needs.

The operations manager told us there were regular staff meetings for all levels of staff. We were told a manager meeting was due to be held the following week. This demonstrated staff were able to communicate with each other and keep informed about all aspects of the agency's work.

We saw spot checks were regularly carried out by the management team. These are unannounced visits to observe working practices and check records associated with people's care. The checks covered areas such as, medicines management, care and support plans and health and safety. The checks were recorded and any improvements needed or examples of good practice were documented. For example, 'X needs full review'. This meant the agency could be assured staff were providing people with personal care that was appropriate to their needs.

Emergency plans were in place for events such as lack of staff due to an accident or pandemic, loss of telephone network, severe weather and disruption to the agency's finances. Plans identified possible problems and the disruption they might cause, described the preventative measures in place and outlined contingency plans. This showed us the agency was prepared and able to deal with foreseeable adverse events minimising the risk these might pose to delivering care to people using the service.