The Care Division Limited

The Care Division - Poole

Inspection report

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Date of inspection visit:
13 September 2016
14 September 2016
15 September 2016

Date of publication:
18 January 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This comprehensive inspection took place on 13, 14 and 15 September 2016. We gave notice a day beforehand to ensure the registered manager would be available. We last inspected the service in July 2014 and found that the service was meeting the regulations.

The Care Division – Poole provides care and support to people with learning disabilities in their own homes. Some people have domiciliary care, with staff visiting at set times during the week, and others have supported living assistance, with staff present for most, if not all, of the day and night. At the time of our inspection, there were 67 people receiving a personal care service.

The service had a registered manager, which is a condition of its registration. 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.

A manager was registered for The Care Division – Poole who no longer worked there. Following the inspection she submitted an application to cancel her registration and is no longer registered.

The ownership of the service had changed at the start of 2016. The new management team were seeking to foster an open and inclusive culture. They were finding ways of promoting people's involvement in the service, including setting up a forum for people who used the service and producing more information in an easy-read format. Staff felt confident to share any concerns with the management team and knew how to raise whistleblowing concerns to external agencies such as CQC. Staff recruitment procedures helped ensure that only staff who were suitable for work in a care setting were employed.

People were put at the centre of their care. They were involved in developing their care plans, which reflected their preferences and individual needs. Their rights were protected because staff and management had a working knowledge of the Mental Capacity Act 2005. Staff also understood their responsibilities for safeguarding people against neglect and abuse.

Staff understood people's care plans and provided the support they needed, including support with their health and nutritional needs. Where people had complex and specialised needs, staff had the appropriate support and training to enable them to meet these. Medicines were managed safely.

Where people's care packages allowed, care included support to pursue interests and attend social activities. Some people reported that staff not being able to drive restricted the activities they could take part in. The service had already identified this as an issue and were seeking to incentivise more staff to drive.

There were sufficient staff to provide care safely. If support workers were not available, for example, due to

sickness or leave, supervisory staff based in the office would attend. However, some people told us that support was on occasion cancelled and that their rotas were sometimes late or showed the wrong times. People also said that they were not always informed about rota changes.

Staff were well supported through effective training. They felt colleagues and the supervision process supported them. Where weaknesses in some supervision processes were highlighted, the management team had already started to make improvements.

Views were mixed about communication with the office. Most people and staff viewed this positively. They said that the on-call system generally worked and that it was usually possible to get hold of supervisory and managerial staff when they needed to. However, two members of staff said they did not always receive sufficient communication from the office, for example, to inform them that new staff would be visiting to work a shadow shift.

The senior management team had set up a quality assurance system. This gave them an oversight of how the service was running and any issues that needed attention. There was an improvement action plan based on the results of audits and any known issues. The management team reviewed this regularly.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff had a good understanding of their responsibilities for safeguarding people against abuse and neglect.

Risks were assessed and managed to support people to remain safe whilst being as independent as possible. Accidents and incidents were followed up and trends monitored for any action that could be taken to protect people further.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

People received care from staff who were themselves supported through training and formal or informal supervision.

The Mental Capacity Act 2005 was put in practice so people only received care they consented to or which was in their best interests.

People were supported to maintain their health.

Is the service caring?

Requires Improvement

The service was mostly caring.

People were not always kept informed about changes to their care, such as alterations to their rotas. Whilst some people had a consistent staff team who knew them well, others experienced a turnover of staff.

Staff treated people with respect and compassion.

Is the service responsive?

Good

The service was responsive.

People had a positive view of their care and support.

People received care and support according to their individual needs. Where care packages covered this, they were supported to take part in social activities and follow interests.

Concerns and complaints were taken seriously.

Is the service well-led?

Good

The service was well led.

There was a positive culture, putting people and their experience at centre of the service.

There was a quality assurance system in operation. Management had identified improvements to be made to the service and were taking action to address this.

Legal obligations were understood and met.

The Care Division - Poole

Detailed findings

Background to this inspection

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

This inspection took place on 13, 14 and 15 September 2016. It was carried out by one inspector. We gave notice the day before we arrived because the location provides a domiciliary care service and we needed to be sure that the registered manager would be available.

Prior to the inspection we reviewed the information we held about the service. This included questionnaires returned by some people who used the service. In addition, we received a 'provider information return' (PIR) from the service in July 2016. A 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 visited people in their homes, meeting nine people who received a personal care service and three relatives. A further person provided written feedback. We also spoke with eight staff involved with care and support, two training staff, one of the information technology staff, the registered manager and two directors of the service. We reviewed five people's care records, five staff files and records relating to the management of the service, such as quality assurance questionnaires, accident and incident forms and policies. During the inspection and afterwards, we obtained feedback from five health and social care professionals.

Good

Is the service safe?

Our findings

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. People told us there were sufficient staff to meet their needs. Staff confirmed they were able to get everything done that was needed within existing staffing levels, although their shifts sometimes felt quite pressured. If support workers were not available, for example, due to sickness or leave, supervisory staff based in the office would attend. Missed and late calls were monitored through monthly management reports; those reports viewed did not indicate a problem with missed visits. Another person fed back that at times, "The care office can't find anyone else to cover as staff are off sick so my hours get cancelled" and said that they sometimes had to wait for staff to visit. The registered manager and senior management team acknowledged there had been issues with staff availability during the summer holidays. They had identified reasons for this, including the need for additional recruitment, and started to address these. This included appointing staff to oversee recruitment and developing procedures to address staff opting out of particular services.

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role. Staff files included application forms, details of employment history since leaving school with an explanation of any gaps, photographic confirmation of identity, interview notes, and appropriate references. Staff records also contained confirmation of staff members' entitlement to work in the UK. Checks had been made with the Disclosure and Barring Service (criminal records) to make sure people were suitable to work in a care setting.

People were protected against the risks of potential abuse. People told us they felt safe with the workers who supported them. They had access to easy-to-read information about safeguarding and how to stay safe. Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. There were policies and procedures in place that prohibited staff acting as appointees for finances, helping safeguard people's money. In addition, staff working in '24 hour' services checked cash balances held at each staff hand over.

Risk assessments and management plans were in place to support people to remain safe whilst being as independent as possible. Risks posed by people's home environments were assessed. Other examples of risk assessments and management plans related to particular physical and mental health conditions, behaviour that challenged others, activities and being alone at home. Where people would need support to be safe in event of fire or another emergency they had personal emergency evacuation plans in place. Staff working with people who had particular risks, such as requiring rescue medication during epileptic seizures, were given the necessary training to manage these risks.

In event of concerns or queries about people's care, staff could telephone supervisory staff based at the office. Outside office hours supervisory staff operated an on-call duty system. A member of staff told us, "You've always got back up… You don't ever feel you're stranded or alone". Another member of staff commented that the on-call system generally worked; there had been occasions where they had struggled to get through but this was generally because the on-call staff were already dealing with something.

When people had accidents, incidents or near misses these were recorded and monitored to look for developing trends. Each accident or incident was recorded on the service's computer system and was reviewed by senior staff for any immediate action to be taken to protect the person. The senior management team had oversight of trends in accidents and incidents through monthly management reporting.

There were safe medication administration systems in place and people received their medicines when required. People's medicines were recorded on medicines administration records (MAR), on which quantities of medicines received were recorded and which staff initialled when they administered medicines. MAR were audited each month to check the quantities of medicines tallied with what was recorded, and that staff had completed the MAR properly when they had administered medicines. The audits were effective and identified staff errors in recording. The MAR we viewed contained the required information and had mostly been completed correctly by staff, although there were some gaps in relation to some people's creams and specialist toothpastes.

Some people we visited had medicines to be taken 'as needed' (PRN) and had prescribed topical medicines (such as creams, gels and special toothpastes). PRN and topical medication guidelines were not filed for easy reference with the MAR. A supervisory member of staff acknowledged the guidelines for PRN and topical medicines should have been available with the MAR and told us they would put these in place. However, there were systems in place to ensure that PRN and topical medicines were administered safely. Staff obtained authorisation from supervisory staff prior to using PRN medicines. In addition, medicines administration prompts were set in the computerised record system, generating missed medication alerts when medicines had not been recorded as given. These were followed up by supervisory staff.

Good

Is the service effective?

Our findings

A person told us emphatically, "I love [name of shared house]".

People were supported by staff who had access to a range of training to develop the skills and knowledge they required to meet people's needs. Staff told us they had the training they needed when they started working at the service, and were supported to refresh their training. They spoke highly of the quality of the training, which was delivered face to face by the provider's training team. Two training staff told us that staff training was valued and promoted. Core staff training topics covered during induction and refreshed at intervals afterwards included safeguarding adults and children, moving and handling, medicines, emergency first aid, infection control, food hygiene, fire safety and health and safety. They also had training specific to supporting people with a learning disability. Staff records showed that staff were supported to work towards qualifications appropriate to their role. A member of staff who supported someone with complex needs told us they were confident to provide that person's care because they had had the necessary training and support to do so.

Staff reported that generally they were well supported by their colleagues and managers. For example, a support worker told us they were "very happy" and worked with "a terrific team". Another said that if they needed support it was forthcoming. Some had regular planned supervision meetings with a member of supervisory staff, which gave them an opportunity to discuss their training and development needs and any concerns they had about their role. A support worker told us they found supervision "incredibly useful" in terms of being able to reflect on people's care. Others told us supervision had not happened as often as it should because their supervisors had to cancel in order to cover staff absence. However, a staff member commented that although supervision might not happen as often as it should, they could always phone their supervisor if they had any problems. Managers had identified that supervision had fallen behind for some staff and had started to address this. We will check at our next inspection that staff are receiving regular supervision.

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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005. People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. Where someone lacked the capacity to consent to aspects of their care, such as medication and managing their money, best interests decisions had been made to

ensure that staff provided for the person's needs in the least restrictive way possible. These decisions had been reached in consultation with the person, their representatives and key health and social care professionals. Service managers were aware of a Supreme Court judgment in 2014 that introduced the 'acid test' for identifying whether someone was deprived of their liberty. They had asked commissioners of services to apply to the Court of Protection to authorise deprivations of liberty and informed us that they would request this at outset of new services in future.

People's dietary needs and preferences were recorded in people's care plans. Referrals were sought to dieticians or speech and language therapists if staff had concerns about their wellbeing, such as unplanned weight changes or choking. One of the people whose care we tracked had particular needs in relation to fluid intake; staff knew how to provide the correct support and did so.

Overall, people's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. Care plans were in place to address people's needs in relation to their health. Health care professionals told us that staff generally kept them informed of any changes or concerns, although two health and social care professionals indicated that staff could be more proactive and responsive in communicating with them. Another professional commented that communication was open and had improved over the years.

Requires Improvement

Is the service caring?

Our findings

People said they liked the staff who supported them. For example, a person told us, "[Name of support worker] is really, really good with me and a number of the others are". Someone else said of their staff, "They're really nice they are" and described one support worker as being "like a second mum". A further person commented, "The care staff that support me are very helpful and friendly" and "I get on well with every member of staff". One person introduced us to their staff in a way that showed they trusted them and had been able to develop a good working relationship. A health and social care professional commented that staff appeared kind and compassionate and had built good relationships with people. People looked comfortable with their staff, who were attentive and treated them respectfully.

Where possible, people had staff they knew well, but this was not always the case. Some people, particularly those who were supported for most if not all of the day and night, received support from a consistent, established team of staff. Others who were living in new services or who had support for only a few hours a week had more unfamiliar staff. A person who had several hours of support each week said they would prefer always to be introduced to new staff in advance of care visits rather than have new staff simply turn up. Amongst other positive comments about the service, a health and social care professional said a high turnover of staff could be difficult for people who used the service.

Following the inspection the senior management team told us they felt that the service provided a high level of consistency of staff to support people. They explained that some people preferred to receive support from a small number of care workers, and when these staff were not available they worked with people to find an acceptable solution. Similarly, some people had complex needs that staff found challenging to work with, resulting in a turnover of staff and the service needing to introduce new staff to support them.

Four out of 10 people fed back that their rotas were sometimes or always late or showed the wrong times. They told us that sometimes rotas were changed and they were not told of the changes. A relative involved with their family member's support said they had not been told the person's field care supervisor had changed.

Following the inspection the senior management team told us there were few occasions where people did not receive advance notice of changes to rotas or staff visiting. They advised us that rotas were set well in advance and that staff had procedures to ensure any changes were communicated in a timely way. They also told us that some care and support was arranged where a person received a set number of hours per week that could be used flexibly over a four week period. Changes to rotas were requested by both people and the office during the flexible care period, and where support was essential or time / date specific these visits were honoured.

The service had identified prior to the inspection that there was scope to improve communications and had started to address this. They had issued a communications strategy and managerial and supervisory staff had been recruited to enhance communication and develop individual rotas. Internal procedures had been changed to flag time-critical calls on the care system for the staff who co-ordinated care. An additional

manager had been in post from August 2016 to share managerial oversight and enhance communication.

People's records included information about their personal circumstances and how they preferred to be supported. Staff had an understanding of people's preferences, for example, supporting them to arrange their accommodation in a way they liked. Where people were unable to speak, staff knew how they communicated and there was information about their unique ways of communicating in their care records.

One person was experiencing particular difficulties in maintaining a working relationship with staff. There were complexities with the commissioning of their care that made this difficult. The management team were aware of the importance of ensuring that this person's views were heard amongst those of other stakeholders. They were conscious of the importance of advocacy to help ensure people's views were properly represented. They told us that it was difficult for the service to access advocacy as this needed to be authorised by service commissioners.

People were given information about many aspects of their service. A service user involvement policy had been developed, setting out what was expected of staff in involving people in the day-to-day running of their service, in reviews and in changes to their care package. A range of written information had been provided in an easy read format, such as information about care planning, and tenancy and support. Where people wished, they had access to the computerised care record system that enabled them to write their own records and communicate with the office, for example, requests to change the time of a visit or the identity of staff who supported them. Similarly, some people's families, where people had consented to this or it was deemed to be in their best interest, were able to read records of care delivered to give them insight into what the person was doing. This enabled them to have regular oversight of their family member's experience.

Good

Is the service responsive?

Our findings

People's comments regarding their care were positive. For example, a person told us they were getting the right support and someone else said that they were happy with their support, apart from last minute changes to their rota. Someone else fed back, "Most staff do the things I want them to do". A health and social care professional informed us that people on their caseload were generally happy with their support, with staff arriving at the right time and doing what they were expected to. A compliment from another health and social care professional had commented on a person's well informed staff team who understood the person's needs.

People and their relatives were involved in developing their care, support and treatment plans. People's needs had been assessed before they began to receive a service. Care plans were reviewed at least annually. In addition, they were reviewed and updated in between if a person's needs were changing. Where necessary their health and social care professionals were involved. Care plans reflected people's needs, preferences and choices and detailed daily routines specific to each person. They covered areas such as health and fitness, any support needed with personal care, behaviour, medication, nutrition and hobbies and interests. Where necessary, care plans contained detail about people's moving and handling needs and support that was required to manage particular health conditions.

People received the support they needed. Staff understood people's care plans and were able to tell us about the people they were supporting. This included people with complex and specific care needs. The care given was recorded in people's computerised care records.

People were supported to maintain their independence and access the community. Where their care package allowed for this, people were supported to follow their interests and take part in social activities. In one of the shared houses we visited, people were getting ready to go away on holiday with staff to support them. Some people and staff commented that the lack of staff who were able to drive on duty had sometimes made it difficult for people to attend social events. Minutes of management meetings showed the service had already identified the availability of drivers as an issue and was starting to address this.

Good

Is the service well-led?

Our findings

The ownership of the service had changed earlier in 2016 and there were ongoing changes to management, procedures and lines of communication. The management team were seeking to introduce a clearer structure and improve communication.

Views about communication were mixed. Most people and staff viewed it positively. For example, a member of staff said the service was becoming more "professional" and felt more structured and secure. Another member of staff said it was generally easy to get hold of supervisory and managerial staff, although messages were not always passed on. However, a member of staff said they did not often receive communication from the office. A further member of staff commented that day-to-day communication was sometimes lacking, for example, they were not always informed when new staff would be visiting to work a shadow shift. They also said they no longer knew which manager to speak to when they phoned the office. We fed this back to the senior management team and they circulated a reminder for staff of how and when to contact the office and out of hours on call service.

The management team were seeking to foster an open and inclusive culture. A member of staff described the culture of the service as "profoundly positive" and "very person centred… a culture of respect towards clients". Another member of staff stated, "You do have a say and it is listened to… Morale would be horrendous if we weren't listened to and we are". Staff also told us they felt confident to share any concerns. They knew how to raise whistleblowing concerns both within the service and to external agencies such as CQC.

People and those important to them had opportunities to feed back their views about the quality of the service they received. Sometimes this was through informal 'keeping in touch' communication, for example, a person using the service mentioned they had spoken to the registered manager about a member of staff who was often late. People's experience of care was also monitored through spot checks, where staff were observed by a supervisor, and involvement in care reviews. More structured opportunities for feedback included a service user forum introduced earlier in 2016, which had so far met once, and annual quality assurance surveys to various stakeholders. Surveys for people who used the service were presented in a format that was easy for people to read. The most recent survey had been undertaken in January 2016. The findings had been analysed and whilst most were positive, themes of concern were acted upon.

The registered manager had mostly notified CQC about significant events, as they are required to do by law. They acknowledged that there had been two matters about which they had not notified us and confirmed that this was an oversight. We use such information to monitor the service and ensure they respond appropriately to keep people safe.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the service. The operations director was based within the service and another director visited at least weekly. Periodically senior managers undertook a comprehensive service audit. The results had fed through into an action plan for improvements. For example, an audit in June 2016 had identified that risk

assessments were in place but needed more regular updates and a new risk assessment framework was to be introduced. The registered manager and another manager were tasked with reviewing risk assessments to ensure they were comprehensive and in date. Improvements were monitored through regular clinical governance meetings involving the registered manager and other senior managers and deputy managers. There were also smaller monthly audits covering particular aspects of people's care, such as finances and medication. Monthly management reports were discussed at monthly managers' meetings, covering topics such as staffing, recruitment, training, safeguarding, accidents and incidents, and compliments and complaints.