Ashness Care Limited

Ashness Domiciliary Care

Inspection report

286 Philip Lane
London
N15 4AB

Tel: 02088010853
Website: www.ashnesscare.org.uk

Date of inspection visit:
25 February 2016
26 February 2016

Date of publication:
15 April 2016

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

Ashness Domiciliary Care agency is based in Haringey. At the time of this inspection, they provided a floating support service to 25 people living in their own homes and 10 people living in supported living accommodation. Ashness domicilary care agency provides support to people with mental health needs who require support to maintain and develop their independence. This includes prompting people to take their medicines, engaging them in activities and assisting them to maintain their wellbeing and independence.

There is a registered manager in post. 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.

This inspection took place on the 25 February 2016 and 26 February 2016 and was announced.

There were systems in place to keep people safe and people told us they felt safe and happy.

Staff attended relevant training and felt they were supported by the management team through supervision. Staff were subject to the necessary checks before working for the service.

Staff were proactive in working with other healthcare professionals to meet the individual needs of people using the service. Staff completed an annual physical health check with each person to help people to identify their health goals for themselves.

People were involved in their care and felt staff treated them with dignity and respect. Staff knew people well and had an understanding of their individual support needs. Staff provided support as required, such as reminding people to take their medicines and assisting people with cooking their meals.

Staff were responsive to people's individual needs and their independence maintained. People were encouraged to take part in activities of their choice.

Assessments were carried out to identify people's support needs before the support started. These had been agreed with people to ensure the agency provided the care and support people needed. Care plans identified people's specific needs.

People's risks were assessed and people were encouraged to take positive risks to maintain their independence. Although staff knew people well, control measures for managing risks were not always accurately documented.

People staff felt listened to and that the service was well run. Systems were in place to monitor the quality of the service.

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. We found most medicines were safely stored and administered and people received their medicines as prescribed.

People's risks were assessed and staff knew the triggers to look for when people became unwell.

People were protected from the risk of abuse because staff knew what action to take should they suspect abuse.

There were sufficient numbers of staff to meet people's needs safely. The service followed safe recruitment practices when employing new staff

Is the service effective?

Good

The service was effective. There was a training plan in place. Staff had the skill and knowledge to meet people's needs and had a good understanding of the support people wanted.
People were supported to prepare meals and maintain a healthy diet.

The provider and staff understood the requirements of the Mental Capacity Act 2005 (MCA) and obtained consent from people appropriately.

Staff understood the needs of people relating to their on-going healthcare needs

Is the service caring?

Good

The service was caring. Care staff treated people with respect and protected their dignity when providing support.

People were given choice and felt their individual needs were met by the service. Staff understood people's needs and listened to them when providing support.

Is the service responsive?

Good

The service was responsive. Staff were responsive to people's

individual needs and made changes to the way support was provided.

People's choices were respected and staff respected these.

Complaints procedures were in place. People felt confident to approach staff with any concerns.

Is the service well-led?

Good

The service was well led.

Staff were supported by their managers. There was open communication within the staff team and staff felt comfortable discussing any concerns with their manager.

Local commissioners felt the provider was proactive and the service was well run.

The service worked closely with healthcare professionals to ensure the service was able to deliver the support people needed and wanted.

Systems were in place to monitor the quality of the service.

Ashness Domiciliary Care

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 the 25 and 26 February 2016 and was announced. We told the staff before the inspection we would be coming, because we wanted to make sure the registered manager and other appropriate staff were available at the agency's office. The inspection was undertaken by two inspectors.

Prior to the inspection we reviewed information we held about the service. This included notifications received from the service and other information of concern, including safeguarding notifications. Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we went to the agency's office to look at records, including policies and procedures, four care plans and related documents, staff training and supervision, staff rotas and complaints. We spoke with six staff, including the registered manager and director to obtain feedback about the support and care provided. We spoke with five people at the supported living service, and contacted five people who received floating support in their own homes and a relative by telephone after the inspection. We also spoke with a local commissioner about the service.

Good

Is the service safe?

Our findings

People told us they felt safe using the service. One person told us, "I feel very safe here." Another person said, "I feel safe here. I go out for walks on my own, do my own food shopping and visit the local library too."

Staff we spoke with knew people well and were able to tell us the signs they would look for that would indicate someone may be suffering abuse. They were able to tell us the different types of abuse and said that any concerns would be reported in the first instance to their manager and if appropriate action was not taken they would report concerns to external authorities, including the local safeguarding authority, police and CQC. Records and staff confirmed that staff had received safeguarding training.

Systems for managing medicines safely were mostly in place. We found that although medicines were stored in a lockable place, this was not stored in a cabinet fixed to the wall. Staff told us that they were reviewing ways to address this issue as the current environment did not allow for this.

People self-administering medicines were assessed and a system was in place for monitoring the risks and how people would manage. This included a check by staff to make sure the person had enough medicine with them when they were away from the supported living service. We checked the records associated with this and found staff documented the quantity of medicine given when a person left the service and when they returned, to ensure doses were taken correctly. Each person who wished to administer their own medicine were assessed for their ability to understand the importance of taking the dose as prescribed as well as other instructions, such as what to do if they experienced side effects. We found this assessment to be detailed and included a check of whether the person could comfortably swallow the medicine in its prescribed form and whether they could open the medicine containers unaided.

People told us they were happy with the medicines support arrangements and had been involved in agreeing them. One person told us they self-administered their medicines under staff observation. Another person told us that they administered their medicines and felt confident and comfortable with this arrangement. A third person told us that they were given their medicines by their staff and this was their preference. Two members of staff documented a check of prescription medicine when a new delivery was received at a scheme and when a person collected their own from the pharmacy. Staff completed a weekly stock check of medicine for people who self-administered.

One person had expressed a wish to complete their own Medicine Administration Record (MAR). Staff had supported them in this by piloting a trial. When the person had not completed the MAR consistently, staff had protected their independence and safety by enabling them to continue filling in their own MAR but monitoring their medicine by completing a weekly stock check.

Where staff supported people who received care from the floating support service, this included routine phone calls to them to remind them to take medicine.
We spoke with a person who administered their own medicine. They showed us a dosette box used to store

their medicine and explained how they made sure they took the correct dose at the right time. The person also told us they collected their own prescription from the pharmacy and showed us how they recorded when they took a dose. We saw staff maintained an administrative record of medicine and had taken appropriate action when a dose had been missed or refused. For example, staff noted if a dose had been taken by the person but not in their presence and the reasons for a late dose.

Staff adhered to a protocol for the use of as-needed (PRN) medicine. We saw this used in practice. For example, one person was prescribed an anticholinergic drug and staff had recorded a discussion with the person about the pros and cons of continuing to take this medicine. This enabled the person to would make a decision as to whether the medicine was suitable for them.

Risk assessments were in place which identified people's individual risks. This covered areas such as people's physical care and mental health, including risk of relapse. This helped staff to identify when a person demonstrated signs that they were experiencing a relapse. Contingency plans included the signs of self-neglect, signs of harm from others and evidence of deterioration in health specific to each individual. For example, staff knew one person well enough to have identified their risk factors for relapse as becoming rapidly withdrawn, refusing to take their medicines and poor personal hygiene.

We found one person did not have an up to date risk assessment outlining specific risks associated with their past offending behaviour. Staff told us that this had not been updated according to records reviewed, since April 2012. However, the provider told us that the risk assessment had been completed and we were shown an electronic copy dated August 2015 of the risk assessment on the second day of our visit. This indicated that staff understanding of risk assessing in this instance was limited. Staff told us that they would benefit from training in this area.

We found staff managed the risks associated with a person going missing by maintaining an up to date record of their personal information. This information was specifically for third party and emergency services and could be rapidly accessed for the use of police and ambulance crews. Although staff updated this information regularly, there was sometimes a lack of consistency in how changes in medicine prescriptions were recorded. For example, one person's dated emergency information sheet indicated they had a prescription for an antipsychotic drug. However, another emergency information sheet did not include this drug on the person's prescription list. As this copy was not dated, it was not possible to immediately find out which of the documents was the most up to date. Therefore this could cause a delay in emergency services accessing information important to a person's welfare.

Staff we spoke with told us they felt staffing levels in supported living properties were adequate. One support worker said, "I've never felt unsafe in the home. We have a solid lone working policy and there's always a senior person who can come out very quickly if we need them."

Staff used their individual knowledge of people to ensure contingency plans included appropriate action to take, including who to contact in the event the person deteriorated rapidly or out of hours. We saw evidence staff used the contingency plans appropriately and in the best interests of people. For example, when police had been involved with one person after an incident in the community, staff correctly identified this as a warning sign of deterioration and involved the person's clinical team and forensic services to improve their compliance with taking their prescribed medicine and provide meaningful daytime activities as a distraction and engagement strategy. However, three contingency plans we looked at were unsigned and undated, which meant we could not verify if they were up to date.

We reviewed staff personnel files for four staff and found that all staff had completed the necessary

employment checks, such as Disclosure and Barring Service (DBS) and proof of identity and address. Staff files contained a completed application form, interview logs and satisfactory references. The provider told us that their policy is to review DBS checks every two to three years. We noted that two staff members working for the service for a number of years did not have their DBS checks renewed for six years. Therefore, the provider was not working in line with their policies and procedures. The provider told us that they had applied for new DBS checks clearance for these staff members.

Good

Is the service effective?

Our findings

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 decisions 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 provider told us that people using the service had capacity to make decisions. Consent to care and treatment was sought in line with legislation and guidance. Staff understood the importance of obtaining consent before assisting people with care. Staff had taken verbal consent for using people's photo for their care plan.. People that were asked confirmed that they had given verbal consent. Staff had received training in the MCA and Deprivation of Liberty Safeguards. The provider told us that he had worked with other healthcare professionals in regards to a best interest decision for the provider to assist one person to manage their finances.

People's independence was encouraged and people participated in activities of their choice. One person told us, "I speak to my keyworker on a regular basis. I go out for food shopping on my own, I shower myself twice a day and visit my [relative]." Records and people confirmed that staff carried out keyworking sessions with people to maintain their independence and involve them in their plan of care.

Care files all had a comprehensive care plan detailing the support for people to maintain balanced diets. However, there was no documentation to demonstrate that this had happened. Daily record logs did not indicate how staff had encouraged people to shop for healthy food items or supported them in cooking a healthy balanced meal. The registered manager and provider told us that staff encouraged people to eat a healthy balanced meal and gave us examples of people they were supporting. They told us that they used a food and fluid chart at other services and would be introducing this procedure for people they supported in the community.

People felt staff were suitably trained. People received help with a range of tasks, including help to access training courses, shopping, cooking, cleaning, going out into the community and help with finances. Comments from people about staff included, "They help me get on with my life. Staff has got the right skills to help me," "They explain things," and "Staff has been a great help to me."

Staff told us they received regular supervision and felt supported by the registered manager and provider. This was confirmed by staff and staff supervision records reviewed. One staff member told us that monthly staff meetings and monthly supervisions helped them to provide effective care. Another staff member told us that the provider had supported them to undertake a level 3 NVQ in health and social care and felt the standard of training in areas such as safeguarding, infection control and fire safety training was very good. They said, "The fire safety training for the home was excellent. We took part in a live demonstration of how to use different fire extinguishers and a simulated evacuation." Staff identified areas where training could be improved, such as regular refresher training and updates on social care regulations, particularly around the care of people with community treatment orders and who lacked mental capacity, understanding risks and

risk management, and supporting people on drug recovery plans. Although staff had been trained in medicines administration, staff understanding of the types and side effects were limited. For example, staff were unclear whether they kept controlled drugs on site.

From speaking with staff it was clear they had a good understanding of how to manage verbally challenging behaviour and aggression. For example, one support worker said, "We get to know people very well. I know specifically what the triggers to aggression can be from the people I work with most often. I also know that when someone starts talking in an irrational way, this usually means they are in some state of distress or anxiety. I stop the conversation and we work out together what is bothering them."

We saw evidence that staff were proactive in working with other healthcare professionals to meet the individual needs of people using the service. Staff completed an annual physical health check with each person. This included a check of their diet, exercise, and smoking and drinking habits. People could use this check to identify health goals for themselves, such as to stop smoking or start an exercise plan. We saw the health check also included input from each person's multidisciplinary health team, including psychologists, community support staff and the recovery team. People used this health check to describe any symptoms, whether physical or psychological, and staff documented appropriate action, such as a GP appointment. A support worker told us the annual health checks were useful tools to help structure improvements in habits. They said, "It helps people to have goals and we've seen this works well. Someone I look after switched from cigarettes to e-cigarettes a little while ago and they're sticking to this, we're both really pleased."

Staff maintained a record of the dates and outcomes of appointments with GPs, dentists, opticians and phlebotomy services. We asked a support worker about this. They demonstrated good knowledge of the individual health needs of people they provided care for. For example, one support worker explained how they worked with a community alcohol liaison team to provide structured support to someone recovering from alcohol misuse. This included their understanding of how alcohol could interact with prescribed medicine and strategies they used to prevent this from happening.

Staff understood the needs of people relating to their on-going healthcare needs. For example, one support worker provided care for a person who frequently missed medical appointments because they lost letters from their GP and community support teams. Staff had arranged an agreement with this person to have medical appointment letters sent to their key worker. This member of staff would then make sure the person made the appointments by providing as many reminders as they needed. We saw that for another person who had stopped taking their medicine, staff had involved the person's care coordinator as part of a community treatment order. This allows people to receive care and treatment in the community under the Mental Health Act 1983. Staff immediately contacted their GP and involved the rest of their clinical team if needed. We found documented evidence of the involvement of the community rehabilitation team in care records reviewed.

Good

Is the service caring?

Our findings

People told us that they were treated with dignity and respect. One person told us "I give them [Staff] the thumbs up." Another person told us, "Yes, I am treated with dignity and respect." At the supported living service we observed some good interactions between staff and people using the service. People were relaxed in staff presence. We saw that staff knocked gently on people's room doors and waited for permission before entering.

Each person had a signed agreement with the provider, which established the responsibilities of each party. This included requirements staff needed to make to keep people safe, such as regular one-to-one meetings. This agreement also included a commitment from staff to consult people before changes to the service were implemented, treat people with respect and ensure their freedom of choice was maintained, and to work closely together to ensure community rehabilitation was successful. We saw that people were given a welcome pack to the service and evidence of these were in people's care plans. This included the provider's 'philosophy of care', the standard of staff training, the complaints policy and the direct line number to the director.

Staff completed a care and support plan for each person, which was updated every six months. We found staff asked each person to influence, agree to and sign their monthly care plan updates. This included the level of support each person needed for tasks such as managing nutritional intake and personal hygiene as well as with managing shopping, cooking and cleaning. People said they felt supported by their keyworkers and that they felt listened to when they wanted to talk about things. People also signed and commented on their keyworker reports, which included details of their health and social routines. Recent comments included, "Read and understood comments" and, "Ok with service at present." We asked a support worker about this. They said, "People very much live here, it's not usually just a short term place for them to sleep. We get to know them very well and they grow here."

We spoke with a support worker about their work with a person cared for as part of the floating support service. They told us this role was in place to support the person to leave their house and to get out and about in the community. They said, "I try and get [person] to leave home and come with me to a coffee shop. This really helps with their confidence and feeling of being empowered. I also support them with daily decision-making, particularly around food choices and maintaining a healthy lifestyle. Just helping them to get into a routine or healthy habits can help a lot."

People were involved in the planning of their care and said that staff helped them to do things that helped them to live independently. One person told us the office always rung if there was a problem with staff attending. People told us they liked being independent, were able to go out shopping, visit family, carry on with social activities such as visiting libraries and go for walks. A relative told us that the staff helped their relative with their finances and paperwork, "He [staff member] goes above and beyond. He is totally reliable and fills me with great confidence."

Where people lived together, they were given choice of being on their own in their rooms or spending time

together in the kitchen or lounge. One person said, "I like cooking, I cook for myself; staff help me in the kitchen." Another person told us, 'We like the same music, so we play radio loud and enjoy listening to music, together.' A third person said, "I read books and I am a member of local library, when I am not downstairs in the lounge or kitchen, I am in my room creative writing."

Good

Is the service responsive?

Our findings

Each person using the service had a named keyworker. This member of staff worked closely with the person to support them on a day-to-day basis, including encouraging them to participate in activities and discouraging them from using illegal drugs. We found evidence staff had tried to identify specific activities for each person to avoid the risks of social isolation. In some cases we found evidence of the action staff had taken to find help people find appropriate activities. For example, staff had noted in one person's care plan, "Encourage to participate in social activities e.g. days out in the community" and "Find areas of interest and encourage [person] to pursue it." In this person's keyworker record, we saw they had been encouraged to visit friends, go out on trips and overnight stays with family and to entertain friends in the home. A relative told us that as a result of staff supporting their relative they had significantly reduced their risk of isolation.

Staff had supported one person to find a local gym to meet their personal budget and exercise needs, and another person to sign up to a martial arts programme. When a person had expressed a wish to visit family abroad, staff had worked closely with them to plan a trip within their budget and to put into place strategies they could use to manage their mental health while away from the service.

We asked staff about how they supported people. One support worker said, "We support people with everything to do with their wellbeing. This includes going grocery shopping with them, planning life goals and helping them apply for work and education. I found one person seemed much more relaxed and content when they were in the garden so we started gardening together, they really enjoy it and it keeps them active." Another support worker said, "We really focus on promoting independence so it's okay if someone doesn't want a structured activity but we want to know they're getting out and about and aren't feeling lonely or isolated."

Keyworkers completed a monthly record of each person's progress and care. The record included key issues such as if the person had stopped taking their medicine and what this could indicate in terms of their care needs. Staff used keyworker reviews to update individual risk management plans, such as each person's visitor privileges. It was clear keyworkers understood the personality and needs of each person they supported and their reviews were individualised. For example, reviews included consideration of the person's psychological and physical health, compliance with prescribed medicines, drug and alcohol use, their ability to manage personal finances, discussion of mental health advocacy, daily living skills and daily activities. Staff indicated where a person had a reliable social network and how this helped them to remain active and socially stimulated. People were asked to write down their comments on keyworker reviews and to indicate if they agreed or disagreed with any changes. Recent comments included, "This section is very accurate and keyworker's view on [my] social network is spot on" and "Am very happy with this section."

Staff had been responsive to the needs of a person who had requested a change in keyworker. For example, the person had raised some concerns over their relationship with a keyworker and had asked to work with a different member of staff instead. A senior support worker had facilitated this change and recorded the outcomes of meetings to make sure the new relationship met the needs and expectations of the person. Another person had indicated during their keyworker review they would like some support with debt

management, which we saw staff had readily provided.

We found a proactive approach from staff in signposting people to careers advice, professional development and community college services. For example, staff had supported one person to undertake a business studies course at college, which we saw they had made progress in. Staff had worked with a person to update and improve their CV and with another person to secure a volunteer work placement.

Staff completed a placement review with each person on an annual basis. This review was used to update each person's risk management and contingency plan, in relation to identifying the early warning signs of a relapse. The review included input from the district nurse, community recovery team, psychologists and GPs. From looking at two placement reviews we saw keyworkers demonstrated a clear and detailed insight into the needs and behaviour of people. This had led to staff acting quickly on the early warning signs of a person relapsing because they had noticed as part of the review a change in the person's behaviour and information from a colleague relating to suspicious packages being delivered to the home.

The provider had a complaints policy in place and people using the service knew how to make a complaint. People told us that they were able to raise their concerns with their keyworkers. Most people spoken with said they did not have any complaints and said that staff were usually on time. People told us that staff did what was asked of them rather than simply carry tasks.

Good

Is the service well-led?

Our findings

People and staff said that the registered manager and provider were approachable and supportive and they could speak to them whenever they wanted to. The provider and registered manager were knowledgeable and had a number of years' experience of working with people with mental health needs.

People told us they felt the service was well run. One person told us that staff were pleasant, "More like a family." Another person told us that staff "do a good job."

Staff spoke positively about the support they received from managers. One support worker said, "I think we've got everything we need from managers. They're always there to help and this means we look after people better because we're more supported." Staff said they were happy working for the provider who provided them with the support they needed to effectively carry out their role. Staff supervision demonstrated that staff were being supported by the registered manager and their development action points followed through. One staff member said, "I am supported well and offered professional development opportunities. If I was not happy with the management, I would not be here."

We saw evidence of good partnership working with other agencies including the Community Mental Health Team, sheltered accommodations and relatives. The provider regularly attended focus groups and local authority provider meetings. This was confirmed by local authority commissioners who told us that they felt the provider was proactive and the service well-led. The provider's involvement in these groups enabled them to keep up to date with changes to working practises and to improve the quality of the service.

Systems were in place to monitor the quality of the service. We were shown a copy of an audit form with dates of when external audits took place. We were unable to verify this as copy of the latest report had yet to be provided by the registered manager. Weekly audits included medication and health and covered compliance with medicines and issues with self administration. Other audits included care records, cleaning and health and safety. We saw that there was a system for obtaining feedback from people through the service key working process.

Incidents and accidents were recorded and the outcome of these documented. We saw that learning from incidents took place and changes to the way the service was run implemented, for example new visitors arrangements following an incident involving a visitor to the service.