Pembroke Care (Reading) Limited

Pembroke Apartments

Inspection report

34 Alexandra Road
Reading
Berkshire
RG1 5PF

Tel: 01189414200
Website: www.pembrokecare.com

Date of inspection visit:
18 April 2017

Date of publication:
12 June 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was completed on 18 April 2017 and was announced. Pembroke Apartments provides domiciliary care services to people within their own homes and within a supported living service. This allows people to reside within a community setting, holding their own individual tenancies. This can include specific hours of required support whilst promoting the person's independence and well-being. At the time of the inspection15 people using the service received personal care assistance.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they had been involved in the planning of their care. They felt that the service provided exceptionally responsive care, often going above and beyond what was expected of them. Care plans provided details on how to support people in the way they wanted. This allowed people to remain involved in the management of their support package, and ensured it was effectively delivered. People's care plans were updated as required, and the staff appropriately made changes.

People told us that they felt safe. Staff were able to explain signs of abuse and what they would do if they suspected anything was wrong. The service had systems in place to ensure sufficient suitably qualified staff were employed to work with people. They were matched to meet people's needs, in terms of language, knowledge, likes and dislikes. The staff team was consistent, remaining with the provider for long periods of time. This allowed the care to be consistent and people to feel safe with staff.

People received care and support from staff who had the appropriate skills and knowledge to care for them. All staff received comprehensive induction, training and support from experienced members of staff. We were told that the constant presence of management, made certain care was delivered to a high standard. Staff reported feeling supported by the registered manager and the management team. They said they were listened to if they raised concerns, and were kept abreast of any operational changes.

People who could not make specific decisions for themselves had their legal rights protected. People's care plans showed that when decisions had been made about their care, where they lacked capacity, these had been made in the person's best interests. Staff had an understanding of the Mental Capacity Act, and used the principles when working with people.

People stated that they felt the service was respectful and preserved their dignity and independence. Where possible choice was given and the person was encouraged to complete tasks independently. This promoted well-being for the person.

People were supported with their medicines by suitably trained, qualified and experienced staff. Details

were provided on each person's file on what the medicine was for and how this needed to be administered. Where required, relationships with external health professionals had been developed. This allowed people to receive a good quality of support from staff who were kept abreast of any changes to people's health needs.

People told us communication with the service was good and they felt listened to. People felt they were treated with respect, with staff preserving their dignity at all times. The service was described as "wonderful" by many of the people we spoke with.

The quality of the service was monitored regularly by the manager, however there was no documentation in place to evidence this. Subsequent to our visit, the manager created paperwork to illustrate when this was completed, allowing a paper trail to be maintained. A quality assurance audit was completed annually with an action plan being generated, although this was not always followed up on, or evidenced. Feedback was encouraged from people, visitors and stakeholders and used to improve and make changes to the service. We found evidence of compliments. Whilst no complaints had been received in the last 12 months, management were able to describe what protocols they would follow should an issue arise.

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.

People were safeguarded from abuse and staff understood how to report any concerns.

There was a robust recruitment procedure in place. People were kept safe with the current staffing ratios, and the matching of staff to clients.

Medicines were managed safely, with details provided on the use of these.

Is the service effective?

Good

The service was effective.

People and where appropriate their representatives were involved in making decisions about their care. The provider aimed to offer a homely service.

People were supported with meals and drinks of their choice that met their dietary needs. When necessary people were supported to eat and drink.

Staff received regular supervision and training.

Is the service caring?

Good

The service was caring.

Staff were caring, patient and respectful, involving people in decisions where possible. They respected people's dignity and privacy.

Staff knew people's individual needs and preferences well. They gave explanations of what they were doing when providing support.

Is the service responsive?

Good

The service was responsive.

Care plans reflected people's needs and were reviewed regularly as people's needs changed. The views of people were listened to and incorporated in the care plan.

There was a system to manage complaints and people felt confident to make a complaint if necessary.

Is the service well-led?

Good

The service was well-led. Staff and professionals found the management approachable and open.

Audits were completed annually identifying where improvements were required and action was taken to improve the service, although this was not always documented.

Computerised systems used ensured that the registered manager had a thorough overview of all documentation and whether this was appropriate and up to date.

Pembroke Apartments

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 18 April 2017 and was announced. The service was given 48 hours' notice of inspection, as it provides domiciliary care to people within their own homes, and as such staff may not be in the office. We needed to be certain that senior staff would be available to support with the inspection. The inspection was carried out by one inspector.

Before commencing the inspection we sought feedback from people, staff and professionals who are associated with the service. Local authority reports and notifications were used to inform the inspection process. Notifications are sent to the Care Quality Commission by the provider to advise us of any specific events related to the service. This service had not been inspected before and therefore, we were unable to use previous inspection reports to provide any background information.

We were unable to review the Provider Information Return prior to commencing the inspection process, as this had not been received by the provider. 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. In addition the questionnaires completed by one person who uses the service, one relative / friend, one community professional and eight staff were also reviewed.

The care plans, health records, medicine records and supporting documentation relevant to care were seen for six people. In addition, a sample of records relating to the management of the service was reviewed. These included staff records, complaints, quality assurance surveys and reports, audits and health and safety checks. Staff files, including recruitment, training and supervision records, were seen for five staff employed by the service.

We spoke with five members of staff during the inspection process. This included two managers, the office manager, and two care staff. In addition we spoke with five people who use the service and two

professionals.

Good

Is the service safe?

Our findings

People were kept safe, by robust recruitment procedures. This included obtaining references for staff in relation to their character and behaviour in previous employment and a Disclosure and Barring Service check (DBS). A DBS enables potential employers to determine whether an applicant has any criminal convictions that may prevent them from working with vulnerable people. Recruitment checks included a declaration of health and fitness, a documented interview process, reference character checks. All checks were obtained and qualified prior to employment being offered. We found that some staff did not have gaps in employment explained, we discussed this with management and this was rectified.

People reported they felt safe with the service they received, and the staff who came in to support them. When asked one person said they felt "oh absolutely safe, as safe as one can be", another person said, "The girls are wonderful, they always make sure you are okay and safe before they leave". The staff team we spoke with had a comprehensive understanding of safeguarding and the whistleblowing procedures. Staff were able to describe both types and signs of abuse. When asked what they would do if they witnessed abuse, no staff spoken with hesitated in responding "report it immediately". We were further told staff would use the whistle blowing policy if they felt that they were not being listened to.

Safeguarding training had been completed by all staff who were working directly with people. This was refreshed regularly with training also being offered to staff working within the office. Staff were able to describe the external professionals that needed to be contacted in circumstances where there were concerns of abuse. Staff said that they felt the management would appropriately deal with any concerns should any arise, as the family atmosphere had always been on "treating people as you would want your relatives treated – safely". Staff reinforced that there had never been a need to use the safeguarding policy to date.

People were generally kept safe with the use of risk assessments, which provided details on how to enable people to engage in activities without restricting them. For example, if people wanted to access the community but had mobility issues, all potential risks were assessed to enable them to partake in their chosen outing, even if this was not with staff. However, not all risks identified had documented risk assessments in place. Whilst staff were able to identify how to keep people safe in such circumstances, there was no documentation in place to verify this was the agreed protocol. For example, there was no documented risk assessment in place for crossing the road for a person where this risk was identified. However, when we spoke with staff it was clear that they had procedures in place to minimise the risk. We discussed this with the managers, and were reassured that appropriate documents would be drawn up. This would confirm with staff that they were using the correct procedures, whilst also ensuring any new staff would know how to keep people safe.

People were assisted with their medicines by staff who were trained and competency checked prior to administering medicines. Each person's care file contained a comprehensive outline of the medicines they were taking, and the reasons for this – where applicable. Staff were following detailed guidelines of when and how these should be given. The service was in contact with the local GP whom guidance was sought

from should a person refuse or dose of medicine be missed. This ensured that all medicines were handled safely.

There was a system in place to monitor incident and accidents, although none had been reported since implementation of these records. Systems were in place for trends to be noted, which would then alert the manager to complete written guidance to prevent the likelihood of similar incidents.

The service employed a set number of staff to work specifically with people living in the supported living service and for the domiciliary care. This meant that people received both a regulated activity and other elements of support from staff they knew. This meant that consistency in approach was maintained and people felt safe with the support that they received from the service. One person said, "[name] she is just wonderful. She will come in and help, she's laughing whilst helping me… always makes me feel safe knowing she's coming."

Good

Is the service effective?

Our findings

People were cared for by a team of staff who had a comprehensive induction. This included completion of training the provider considered mandatory and additional training that would be supportive to their role. For example, some staff completed specific social care training which was relevant to the people they supported, including recognised qualifications like the NVQ. Before commencing work, new staff shadowed experienced staff until they felt confident to work independently.

The training matrix showed that 100% of all required and suggested training had been completed or was booked for people as refresher courses. The registered manager and the two managers would complete spot checks on all staff to ensure that they had a comprehensive understanding of the knowledge gained through training. Areas of further development were discussed within supervisions. Whilst the service did not complete formal team meetings, information was shared during handovers, emails and passed on as management visited the site. Many of the staff team had been working at the service for a number of years, and had experience that further enhanced their training in delivering effective care. All new staff were expected to complete the Skills for Care induction, this aimed at providing the national minimum standard that staff should have when delivering care.

Staff received regular supervision. This provided both the staff and the relevant line manager the opportunity to discuss their job role in relation to areas needing support or improvement, as well as areas where they exceled. This was then used positively to improve both personal practice and the practice of the service as a whole. Staff told us they found the supervision process useful. One said, "It formalises everything." Another member of staff said "It allows me to learn more about my job, seek guidance… very useful".

Staff spoken with were able to explain how they ensured they met the requirements of The Mental Capacity Act 2005 (MCA). This is a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. People we spoke with reassured us that staff understood the principles of the MCA. One person told us "They always ask me before they help me with anything. If I don't want help at that time, they don't push me."

Care plans reinforced the need for seeking consent. For example they read, "ask [name] before assisting with personal care." All staff were able to give examples of how choice was offered. One staff said, "We have to respect their choice. If they don't want to do something yet, we cannot make them". Staff were able to describe examples of best interests decisions, for example when medical advice needed to be sought, and the person may not be in a position to make the decision. If a person required additional people to help make a decision, this was appropriately documented. People reinforced that their dignity was preserved at all times when receiving assistance with personal care. "They cover me up, make sure the doors are closed.

They give me time on my own. They are wonderful".

Care plans illustrated what foods people liked to eat, and if applicable what assistance was required. People said that the food was well prepared and tasty. If they did not want what the supported living scheme offered, alternative food was provided.

Each person had a profile that covered health information. This included medical issues such as dietary requirements or any medical issues that may require additional support. The profile also included cultural and religious factors, which were catered for as required. The service worked very closely with external professionals, specifically the local GP practice to ensure people had all medical needs met.

Good

Is the service caring?

Our findings

People told us that the service was very caring. One person said "Oh they truly are wonderful, I cannot fault them". Another person told us, "[name] has looked after us as family should. She is a wonderful, wonderful girl". People and their families reported that they were treated with dignity and care. One member of staff reinforced this point, "you have to look after them like you would want your family to be cared for". We found during conversation with the managers, that this was an important part of the selection and induction process. Training reinforced the necessity of treating people in a caring manner, and offering a service with a "family feel".

Management reinforced how they wanted the service to offer a "family environment" to people. Staff and management would pop in to see people offering to make drinks or snacks. This was to ensure that people remained hydrated and had enough to eat and were okay before the scheduled next call, or when people appeared to be low in mood. This was an example of how the service cared exceptionally for the people who used the service. This impacted positively on people. They felt a part of a wider group of people, and did not see staff as workers but "as family", making them retain a sense of belonging within the wider community and enhancing their well-being. One person told us, "They are wonderful here [registered manager] and the boys, the staff, they are always helping. They come in to check on us, check we are okay. It's a wonderfully caring service."

People were visited by consistent members of staff, who had been chosen based on their knowledge and skills related to the needs of people. We were told that the staff specialism and personality was matched to people. This meant that people were able to talk to staff about things that were important to them, developing a relationship. For example one person wanted a young person to help them, who could spend time with them and talk about life today. The service ensured this was provided.

People told us they were involved in decisions related to their care. One person told us, "oh absolutely. I was asked how I wanted to be helped. They really do things the way I want". Another person said, "I was asked how I wanted to be helped. If I need to change anything, or need some more help, I can just call [managers]". Care plans were reviewed and updated on a monthly basis or as required. We found that old information was not always removed from the care plans, which could potentially lead to confusion if regular staff were not working. We spoke with the managers who agreed that the information needed to be removed from the documents.

We found that people were shown respect and staff and records were able to describe how they maintained this. For example, care plans illustrated how people wished to be addressed. Staff were advised what to do upon entering people's living space with specifics on how to greet the person. One person said, "I cannot fault them… a wonderful bunch".

All staff who worked directly with people had access to computerised programmes that updated care plans, or provided information as a matter of urgency on their tablets. This meant that staff were kept abreast of all care and support needs at all times. A list was retained on the computerised system in the office that

highlighted who was involved in each person's care. All records for people were kept securely in a paperless computerised system, with restricted access, which could be monitored by management remotely.

Good

Is the service responsive?

Our findings

People's needs were assessed prior to support being offered to them. This was to ensure the service was able to provide the support needed. This stage involved family members or health professionals at the request of people to help provide additional information. The attending member of staff would complete the initial assessment that would allow a care plan to be developed from this. Risk assessments were completed during the initial assessment to further inform the care document, and were updated as needs changed.

Care plans focussed on the individual for whom support was provided. Information such as, their past life history, how they liked things done and how they communicated their everyday care needs were included. A one page synopsis with the client's photograph was provided to all staff. The electronic tablets staff carried with them, contained a brief version of the care plan for them to refer to during calls. This overview contained the most pertinent information needed when delivering care. Care plans were amended as required, with sign off highlighted when these had been reviewed or amended, and by whom. The care plans were generally informative. Management had recently introduced a new programme that would enable a care plan to be created from information provided in a risk assessment. The care plans this generated were over complicated and on occasions inaccurate. For example one care plan stated that a person was incontinent, with the second paragraph stating that they could manage their continence independently. We raised this with the managers, as this confusion could cause issues if regular staff were not attending. We were reassured this system would not be used until correct information could be generated. All documents were going to be reviewed by the managers to ensure they were reflective and responsive to the needs of people.

The service responded to people's individual requirements. One person told us that his wife initially required the support and care. However, he did not wish to be away from his partner. When he spoke with the registered manager about this, he helped them to find a smaller provision that both could be together in, and would enable his wife to receive intensive support. "We've been married for 60 years. I couldn't be without her… [registered manager] made sure I wasn't! We've been very well looked after."

Another person told us how staff had enabled her to continue with her passion for painting. They helped by providing still life for her to paint, and helped collect provisions and tools she needed to do this. She told us "I have always loved to paint. This is my life. They [staff] allow me to continue with this. My days are focused by me painting".

There was a complaints procedure available and information on how to make a complaint was provided to people when they took on the services. People told us they were aware of how to make a complaint. One person said, "I know how to and who to complain to, but I honestly have nothing to complain about. They are very good". The manager was able to describe what procedures would be implemented if a complaint was received.

Good

Is the service well-led?

Our findings

The service had an honest and open culture. Staff showed an awareness of the values and aims of the service. For example, they spoke about giving people exceptional care and a family away from home. One staff member said, "I've worked here for many years, we've always valued people, just the way that we are valued by [registered manager]." The constant presence of management reassured staff on how to support people. They reported that if at any time there was uncertainty or staff were unwell, they could always rely on the managers to step in.

We found there to be good management and leadership. The registered manager (who was also the nominated individual) was supported by a strong management team. They valued the team and role modelled how they wanted care to be delivered to people. One person said, "if there is anything wrong, you can count on [registered manager] or the boys to be here and help."

Quality assurance audits were completed annually by the registered manager. These sought feedback from stakeholders, people, and staff. This information was then used to create an action plan. However, the action plan was not always followed up on by recording how tasks had been completed. The manager noted the importance of ensuring conclusive evidence was retained of any changes required as a result of the audit, reiterating this would be completed from the next audit.

Staff told us the registered manager and management were open and approachable and created a positive culture but were not afraid to speak to staff if they did not perform to the standards expected. Staff reported that the registered manager would go out of his way to support them and provide expertise if they were unclear of how to deal with something. One member of staff said. "He's always available. He listens and helps. I can talk to him about anything, even my personal life".

The communication within the service was good. The service would send out emails to staff with any amended policies, updates in service agreements, as well as changes to rotas. This was an excellent way of communicating any changes related to care plans, as well as reminding people of upcoming training, social events and new staff appointments. The managers recognised that team meetings were not held, however, felt that this means of communication was a successful way to communicate with staff. This point was reiterated, "I get any updates by email. It's great. I can read what's going on as well as seek help as I need from them [managers] when they are around."

The registered manager had an open door policy. People using the service, staff, relatives or other professionals had the opportunity to raise any concerns or complaints with the registered manager at any time. We were told that there had been no concerns or complaints received. We checked the documentation and found that there had been no issues raised in the last 12 months.

The service did not have documents that evidenced audits of paperwork had been completed, We noted through discussion with management that audits had been completed but not documented to evidence this. We spoke with the manager in relation to this. A document was subsequently developed by the

manager to be used monthly when they audited all documents pertinent to people's care.