Advance Housing and Support Ltd

Dashwood

Inspection report

1-6 Dashwood Court
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Tel: 07736100147

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Dashwood on 20 July 2016. This was an unannounced inspection.

Dashwood is a supported living service that provides personal care and support to people with learning disabilities. Supported living is where people live in their own home and receive care and/or support in order to promote their independence. The care received is regulated by the Care Quality Commission (CQC), but the accommodation is not. It aims to enable the person to be as independent as possible, The service covers the Banbury area and currently provides support to seven people living at Dashwood. They also provide an outreach service to 14 people and this is run from an office in Dashwood Court.

There was no registered manager at the service at the time of our inspection. A registered manager is a person who has registered with the CQC 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. The service had not had a registered manager since January 2015. The CQC received an application from the manager in April 2016 to become the registered manager. However, the outcome of this was not known at the time of the inspection.

People and their relatives said they felt safe. The provider had policies and procedures in place in relation to safeguarding adults. Staff had received training and understood how to report concerns. People's care records contained risk assessments. These identified any risks related to each person and described the measures and interventions to be taken to manage risks. There were sufficient staff to support people safely. Staff had been checked before they started working for the service to ensure they were suitable to work with vulnerable adults. Medicines were managed in a safe way. We looked at how records were kept and spoke with the manager about how staff were trained to administer medication and we found that the medication administration process was safe.

Staff training records showed staff were supported to maintain and develop their skills through training and development opportunities. Staff we spoke with confirmed they attended a range of learning opportunities. They told us they had regular supervisions with the manager, where they had the opportunity to discuss their care practice and identify further training needs.

People told us they were involved in all day to day decisions about their care and records evidenced their consent about support they received. Staff had received training about the Mental Capacity Act 2005 (MCA) to ensure people were supported in line with the principles of MCA. However decisions were not always documented appropriately.

People were supported to shop and maintain a healthy diet. Care records showed people's health was monitored and referrals were made to other health care professionals where necessary for example, GP and mental health team.

People felt that the staff were caring and helpful. People told us they were treated with dignity and respect by staff.

People had been assessed to see what support they required before moving to the service. Care plans were written clearly and in a person centred way. Care plans included personal histories and described individual care, treatment, wellbeing and support needs. These were regularly reviewed and updated by the care staff and the registered manager.

People were encouraged to plan and participate in activities that were personalised and meaningful to them. Some people were in employment. We saw evidence of other activities such as social groups and people being supported to be involved in their local community both with support and independently. People were encouraged to take part in meetings to discuss what changes they wanted or to suggest new activities or events.

We saw a complaints procedure was in place and this provided information on the action to take if someone wished to make a complaint and what they should expect to happen next. People also had access to advocacy services and safeguarding contact details if they needed it.

The service had not always notified the CQC about incidents that affected the service. We found that the service had been regularly reviewed through a range of internal and external audits. People, relatives and staff said management were approachable.

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 said they felt safe.

Staff had received training and had a good knowledge of reporting safeguarding concerns.

Risk assessments were in place for people in the service and medicines were managed safely.

Is the service effective?

Good

The service was effective. Staff were regularly supervised and appropriately trained to ensure they had the skills and knowledge to meet people's needs, preferences and lifestyle choices.

Consent was gained by staff and MCA and DoLS training undertaken. Staff showed an understanding of the principles. Documentation had not always been completed to evidence decision making.

Healthy eating was encouraged and people were given assistance to shop healthily by staff.

People were supported to attend health appointments

Is the service caring?

Good

The service was caring. People were treated with kindness and compassion and their dignity was respected.

People and their relatives spoke positively about staff.

Resident meetings were held regularly.

People were understood and had their individual needs met, including needs around social inclusion and wellbeing.

Is the service responsive?

Good

The service was responsive. People had support plans that were individual to their needs and reflected personal preferences.

The support plans were reviewed regularly.

People had access to employment and activities that were important and relevant to them to ensure they were protected from social isolation.

The complaints process had been improved to ensure people had any concerns investigated.

Is the service well-led?

Requires Improvement

The service was not always well led. The service had not had a registered manager in place since January 2015.

Relevant notifications had not been made to the Care Quality Commission as required.

There were effective service improvement plans and quality assurance systems in place to continually review the service including, safeguarding concerns, accidents and incidents, complaints/concerns.

Dashwood

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 20 July 2016 and was unannounced and was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we requested and received 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. The form was completed and returned so we were able to take the information into account when we planned our inspection. We also reviewed previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with five people who were living at the service. We also spoke with three relatives and one person receiving outreach support. We also spoke with five staff including the manager and deputy manager.

We looked at four people's care records and risk assessments. We looked at three staff files to review recruitment, supervision and training records. We looked at audits for maintenance and safety. We reviewed audits and minutes of residents meetings and staff team meetings.

Good

Is the service safe?

Our findings

People told us they felt safe. One person told us, "I do feel safe with them, yes I do". Another person said, "I do feel safe because they help me as much as they can. I do feel that the staff here are always looking out for me. I would call the staff on my mobile if I needed them urgently". A relative said, "[Person] would know who to contact in an emergency, so would I".

The service had policies and procedures in place for safeguarding adults and were accessible to members of staff. The manager and the deputy manager were aware of the local authority reporting process in relation to safeguarding concerns. However, records showed that the service had not always notified the Care Quality Commission (CQC) of reportable incidents. We explained to the manager and the deputy manager that this meant they were not meeting the requirements of their registration. They said they would take immediate action to ensure reporting of necessary incidents were completed and submitted as per the requirements.

Staff received safeguarding training as part of the organisations mandatory training and they were knowledgeable of safeguarding vulnerable adults. We spoke with three members of staff and they were aware of how to recognise signs of abuse and how they would report a concern. One member of staff told us, "I would contact deputy or manager and would do an incident form and online safeguarding referral. I am aware I can go to head office, or social services learning disability team, the police or doctors". Another member of staff said, "I would speak to the manager, go to head office or CQC".

People were protected by having plans in place detailing the support required to manage any assessed risks. The files we viewed contained risk assessments for hazards such as choking, potential slips and falls and risk of burns. One person's record identified they were at high risk of choking. The staff had received training to ensure they understood how to manage this risk. The speech and language therapist had written guidelines for staff to follow and confirmed they were aware of the risk and how to manage it.

Most people took their medication independently and needed minimal support. One person who needed assistance told us, "They remind me to take my medication". Records confirmed staff had been appropriately trained to support people with their medicines. We saw an example of a Medicines Administration Records (MAR) for a person who needed to be assisted with taking their medicines and noted there were no gaps. People's care files contained a list of their prescribed medicine including the dosage and purpose.

People also had risk assessments relating to misuse of medicines, risks of exploitation by others or managing finances. For example, a person received support to ensure they took their medication at the right time. Their relative said "She has one of those Boots daily things (Dosset box) and she takes them herself. I check that she's done it and the staff check as well when they turn up. Pretty fool proof really". People's files also recognised the importance of positive risk taking, such as horse riding. This meant people were supported to pursue their chosen activities even if these could pose risks.

There were sufficient staff to meet people's needs. Comments included, "Yes, I do think there are enough staff here for us although I believe that they're currently recruiting for more" and "I reckon they've got enough staff here really. Sometimes two staff come in to help me out so they must have enough of them to be able to do that". A relative commented "There are certainly more than sufficient staff to look after [person] properly which is what they do well".

Staff said that they felt the staffing levels were sufficient. One staff member told us: "We have enough staff, we have most we've ever had, there's always someone to cover any shifts". The manager told us they were actively recruiting and this was due to increased number of referrals from the local authority.

The provider operated a safe and effective recruitment system. Records confirmed that the necessary recruitment checks had taken place before staff were employed to work at the service. Staff files contained a written application, two references from previous employers, proof of eligibility to work in the UK, proof of identity and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helped employers make safer recruitment decisions and prevented unsuitable people from working with vulnerable adults.

The service had regularly checked the environment for risks such as weekly water temperature checks, fire extinguishers, infection control measures and a deep clean was carried out every month.

A plan to explain what would need to happen if an emergency were to occur in the service was in place. This included contact details to enable communication between staff and external professionals. It also listed a safe place people could be evacuated to locally if the need ever arose.

Good

Is the service effective?

Our findings

People spoke positively about staff and told us they were able to meet their needs. One person said, "Staff help me, I am happy here".

People were supported by staff that were well trained, skilled and experienced to meet people's needs. The training records demonstrated that training such as person centred care, safeguarding, food safety, moving and handling, medication and first aid had taken place. Staff also received training relevant to the care needs of the people they supported, which included Tourette's awareness, sexual health, managing violence and autism awareness. One person commented on the training "I really do think that the training they're given here is very good. I feel confident with them. They give you that impression of knowing what they're doing". A relative commented, "I feel that the staff training is quite good really".

Staff told us the training provided was appropriate for their roles and prepared them well for their roles. One member of staff said, "The induction was very helpful. I wasn't just pushed in. The team gave me the confidence". Another member of staff said, "I had some classroom based training and also shadowing (working alongside an experienced member of staff)".

Staff told us they were well supported to carry out their roles. We saw records were kept of when staff had met with their line manager for supervision. Staff we spoke with confirmed they received regular supervision. One member of staff said, "Supervision is every 4 – 6 weeks, it's a two way process, I am comfortable to bring any issues up". Another member of staff told us, "Yes, I have supervision every month". Staff also received annual appraisals.

People told us they were involved in day to day decisions about their care. We asked one person if they felt the staff listened to them and the person told us, "They do ask us what we want to do at all times and don't try to impose their agenda onto us".

Staff had completed training on the Mental Capacity Act 2005 (MCA). The 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. We saw one person was being considered for surgery. Notes described that a best interest meeting would be needed in respect of this including the medical professional who would be the final decision maker.

People's files reflected their consent was obtained in most cases. One person's file reflected they were asked and had signed to agree that staff could support them with medication and that the staff may enter the person's property if they were concerned about the person's welfare. However, one person's records had been signed by their relative. We advised the manager that the principles of the MCA needed to be followed and a best interest decision made if the person did not have capacity to consent.

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. In supported living schemes such as Dashwood, the service provider must work with the body that has commissioned the service in applying to the Court of Protection for authorisation to deprive them of their liberty to ensure any deprivation is legal. For example, we saw that one person had been assessed as at risk using their kitchen. The best interest meeting had been held and the person's relatives, care manager and the staff from the service were involved. The decision was made that the kitchen would remain closed at all times. However, we did not see any records about the capacity assessment in relation to this decision before the best interest meeting took place. The manager said they had contacted the local authority about this. However, this was not noted on the records and a copy was not made available to us on the day of the inspection. We asked the manager to follow this up with the local authority. Staff showed knowledge of the principles of the MCA. One member of staff told us, "Everyone should be assumed as having capacity unless it's proven otherwise. We support people to make their own decisions and allow them to take risks.

People were supported to shop for healthy food options and, when needed, assisted with cooking. People's care plans showed people were encouraged to eat and drink healthily to meet their nutritional needs. One person told us, "They also help me to shop. They come with me to make sure that everything goes well. They also help me to prepare my meals to make sure that I get the right food and also as I'm not entirely safe when I cook". Another person said, "The staff are very supportive. They come shopping and make sure I'm okay. They do help me with the meals that I cook. They'll let me do what I can but help me where they think they should just to be safe".

People were assisted to have access to relevant healthcare professionals, such as GP's and dentists. People had health action plans in place stating support needed around caring for teeth, hearing, eyes, skin, sleeping. It also recorded any medical appointments. For example, one person required regular blood tests and we noted the staff accompanied the person to have their blood tested and the records of the appointments were made. Another person had been referred to a neurologist for investigations and we saw the appointment letter on this person's records.

Good

Is the service caring?

Our findings

We asked people who lived in the service whether they felt staff were caring and supportive. Comments included; "I do like all of the staff here as they're all very friendly, they're never rude. The staff always care for me, they always help me whenever they can. They'll come into my room to help me whenever it's needed, they don't mind that" and "They definitely care, they're considerate and will do anything for me. They're all very nice, I like them all. They're all very respectful to me". A relative told us, "Staff are very kind, very caring and also considerate. They will willingly do whatever they can for [person] providing they have the staff and the time to do so. I've arranged for them to take [person] swimming shortly. He'll love that". Another relative said, "They (staff) ooze confidence and make you confident in turn. They're all very young but all totally brilliant".

People were supported by caring staff that were enthusiastic and told us they enjoyed working at the service. One member of staff said, "We're all very caring, if we did not care we would not be here, we're doing our utmost best". Staff knew the people they were supporting well. They were able to tell us about people, their interests and their preferences. We saw all of these details were recorded in people's care plans.

People told us they felt staff respected their dignity and privacy. One person said "The staff do respect my privacy, they're always most respectful & friendly. I see them three times a week. They don't come charging in. They knock and wait for me to invite them in. They explain what they want to do and ask for permission to go ahead before doing it". Another person said "They're always very respectful and they do preserve my [relative's] dignity.

People were provided with emotional support when experiencing difficult times. We saw in one person's records they had been referred for bereavement support. A staff member described how difficult it was for the person and how they were trying to support them.

People were able to express their views and were involved in making decisions about their care and support. For example, people could choose which keyworker they had and who they wanted to live with. People in the service were invited to attend regular meetings to discuss any issues together. One person said, "I didn't go to the last meeting but will probably go to the next one when it comes along. Although I tend to be nervous around too many people". Staff knew this person did not like attending meetings but did encourage them to go along or to ensure their views were heard.

Staff told us people were encouraged to be as independent as possible. One member of staff said, "We show them (people) what to do. For example, offer them to cut up food, teach them about oven temperatures, like 'Do you remember what we put the oven on last time?' or the microwave – explain it's for two or three minutes etc." Another member of staff said, "They (people) are priority, I like to help them, it's nice to see people being independent".

Good

Is the service responsive?

Our findings

People's needs were assessed prior to receiving support. This was to ensure the team had sufficient information to support people's identified needs. People's choices, likes and preferences were clearly documented in their care files. For example, one person's file read, "[Person] can be easily upset if there are a lot of raised voices". A person commented, "We do have a care plan each which they do tend to adhere to. They explain what they want to do and, if we're happy, they get on with it".
People's support plans were person centred which meant they put the person's needs first and described what support the person needed to help them achieve what they wanted. This included doing certain activities or going on holidays. The support plans were pictorial, easy to read and were completed by the person and their key worker. Topics included diet, health, stress, planning for the future, communication and relationships. We saw in one person's records a list of words and phrases that a person used. There was an explanation next to each one explaining what the person may be wanting or saying if they used those words. Support plans had information such as photographs of staff, holiday photographs and what symbols were used to communicate.

All support plans were up to date and the next review date was on the document. One person said, "Someone from the Local Authority does come to see me at times to check on me. They have asked me about the support that I get".

People were supported to attend activities of their choice or to carry out jobs. On the day of the inspection we saw people were going to work at a day centre. One person told us they were going out to work later. People's care plans contained information about their preferred leisure activities and how to best support them. For example, one person liked watching TV, the person's care plans stated, "I sit close to the television, staff encourage me to wear my glasses". A person told us," I'm hoping that we'll be going out to a local garden centre sometime soon. That would be very enjoyable and we're both looking forward to it". We saw another care plan where the person wanted to volunteer for dog walking, go to a theme park, go swimming regularly. These goals had been set in April so had not been reviewed at the time of the inspection but we saw evidence that people were doing activities they had listed they would like to do. A person had an activity listed which noted that due to the person's disability they were unable to participate however the person liked to go along as they 'enjoyed the chatting'. This meant their choice was respected.

There were a number of social groups available for people to attend. These included groups within the local community and activities put on specifically for people. We spoke with people about these and they said they knew what was available but chose not to attend at times.

People were supported to seek or maintain employment. We spoke with a person who worked locally and had recently been promoted. Another person said "I've got a job now. I work at a charity shop just down the road. I'm hoping that it will give me more confidence with people".

All people in the service and staff had been given details on how to make a complaint. People's care files contained an easy read guide on how to make a complaint. People commented that they knew who to

contact, "I find [management] easy to speak to and I do know that they'd sort a problem out if I had one" and "I'd have no hesitation in asking [management] to sort something out for me. I do see them both around the building all the time".

The service had recently reviewed the complaints procedure to ensure people received a written response within specific timescales to any complaints made. We saw complaints had been responded to in line with policy. For example, a person had complained about the noise. We saw an acknowledgement letter had been sent and a further letter about actions proposed.

People were invited to regular meetings in the service to discuss any issues they had. We saw minutes from a meeting about attending a barbecue in Oxford. The deputy manager asked people if they were interested in attending a creative writing workshop coming up in Oxford. People had also discussed activities they would like to do, such as another barbecue, their preferences for keyworker and volunteering opportunities coming up. There had also been discussions about moving flats to share with other people. This was being organised at the time of the inspection. People we spoke to said they had been consulted about this and were looking forward to moving with those they had requested to share with. Relatives said they felt involved. One said, "Sometimes they phone me if [person] had a problem at all so they do keep in touch with me, keep me in the loop".

Requires Improvement

Is the service well-led?

Our findings

People and their relatives knew who the managers were and felt able to approach them if needed. A relative said, "They're both very approachable but I would only contact them if other staff couldn't sort it. They do care for him and about him".

People's views were sought by the provider. As these were sent out by the head office and not by the service, the service management did not have any information in relation to results at the time of the inspection. Therefore, any feedback from these could not be considered and acted upon to make the surveys meaningful.

We looked at the records about accidents and incidents. We saw that not all relevant information that should have been reported to the CQC had been sent. We also found the provider had not reported all safeguarding incidents and notified CQC of these appropriately. We advised the manager and deputy manager that safeguarding incidents needed to be submitted in line with CQC guidance detailing what the service must legally inform us of.

The service was managed by a service manager and a deputy manager. The service manager had applied to the CQC to become the registered manager. This had not been processed at the time of the inspection. We saw there were clear lines of accountability within the service and with external management arrangements. There was also an Operational Manager who visited the service regularly.

Staff we spoke with told us the manager and deputy were approachable and they felt supported in their role. One staff member told us, "It's good, staff morale is better since the new deputy has been in post. We all support each other". Another staff member told us, "We can always go to manager or deputy for advice, anytime". There was an on call system available for staff for out of hour's support where advice and guidance was provided. All staff were aware of the procedures and processes to follow in relation to this.

The service held monthly team meetings. We saw records that these had taken place and discussed issues such as training around potential choking risks and manual handling. We saw this had taken place. Before we inspected the service, we received an outcome from the local safeguarding team that the complaints process needed to be improved and staff should discuss this as a team. We saw that this had taken place as stated and the complaints process had improved as a result of this. Staff we spoke with confirmed they had regular team meetings and said they were beneficial to discuss things together.

The manager and the deputy manager ensured the quality of service was monitored and any action taken if needed to address where an area for improvement was identified. Audits in the service had been completed. This included checking of care plans, annual reviews and risk management plans. Care plans were selected monthly and checked through by a manager to ensure they were up to date and complete. However, recording was not always evident around mental capacity assessments and best interest decisions. Records showed that staff files had been regularly audited to ensure all information was contained in them.

Risk assessments were followed up by a management plan detailing how to support the person to reduce the risk. A continuous improvement plan was developed from this to ensure actions were completed. For example, we saw that following an incident, all staff had received manual handling refresher training and the person's file had detailed information about how to move them safely in a hoist.