Next Steps Community Care Ltd

Next Steps Community Care LTD

Inspection report

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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?	Good

Summary of findings

Overall summary

Next Steps Community Care LTD is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults, younger adults, people living with dementia, people with physical disability, people with autism or learning difficulties and people with a sensory impairment. Not everyone using Next Steps Community Care LTD received a regulated activity; Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

The announced comprehensive inspection took place between the 7 and 9 February 2018. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The rating at our previous inspection was good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and on-going monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

A registered manager was 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.

People were kept safe by staff who knew how to recognise and report any potential harm. A sufficient number of staff were in post and any new staff continued to be recruited in a safe way. Risk to people were identified and managed. Trained and competent staff administered people's medicines safely. Infection prevention and control systems were in place and staff cared for people as hygienically as practicable. Systems and processes were in place that enabled the provider to take on-board any learning when things did not go as planned.

Staff were trained and had the skills they needed to meet people's assessed care and support needs. People were supported with their nutritional and health care requirements. Staff worked with external stakeholders who were also involved in people's care. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People continued to be cared for with dignity and respect by staff who showed them compassion. People's preferences were respected by staff who knew each person well and how to meet these.
Staff promoted people's privacy and people could be as independent as they wanted to be.

People's care was person centred and their records reflected this. People were treated equally no matter what their needs were. Concerns were acted upon before they became a complaint. People were given accessible ways to raise concerns. Policies and procedures were in place as guidance for staff should any person require end of life care.

The registered manager led by example and they had maintained an open and honest staff culture. Staff were aware of the standard of care that was expected. People, relatives and staff had a say in how the service was run. The registered manager remained aware of their responsibilities. Staff were supported in their role. Quality assurance, audit and governance systems were effective in driving forward improvement. The service and its staff team worked in partnership with others and people's wellbeing benefited from this.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains 'Good'.	**Good**
Is the service effective? The service remains 'Good'.	**Good**
Is the service caring? The service remains 'Good'.	**Good**
Is the service responsive? The service remains 'Good'.	**Good**
Is the service well-led? The service remains 'Good'.	**Good**

Next Steps Community Care LTD

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 checked 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 announced inspection was undertaken by one inspector.

The inspection took place between the 7 and 9 February 2018. We gave the service 48 hours' notice of the inspection visit because it is small and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. The registered manager also had to arrange for us to accompany care staff during their work and gain consent from people and relatives we wished to speak with.

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. We looked at this and other information we hold about the service. This included information from notifications the provider sent to us. A notification is information about important events which the provider is required to send to us by law.

As part of our inspection planning we requested, and received, information from those organisations who commission care at the service. We asked for feedback from the local safeguarding authority and the community nursing team.

On the 7 February 2018 we visited the service's office to speak with the registered manager, the nominated individual (NI). The NI is the person who has overall responsibility for the management of the regulated activity, and ensuring the quality of the service provided. We also spoke with the service manager, a team manager, six care staff and the recruitment manager. We visited and spoke with four people in their homes

and one person two people who visited the office.

On 9 February 2018 we spoke with two relatives and a community healthcare professional by telephone.

On the 7 February 2018 we observed the way people were being cared for. This was to help us understand the experience of people who could not talk with us. We looked at the care records for four people which included their medicines' administration records and two new staff's recruitment files.

We also looked at records for the management of the service, staff training and supervision planning records, complaints and compliments, and accident and incident records. This was as well as the provider's 2017 quality assurance survey for people, relatives and staff.

Good

Is the service safe?

Our findings

Staff continued to be trained on how to protect people from harm as well as being aware of those agencies they could report any concerns to. One person communicated to us that they were "safe". People were protected from any potential discrimination. Should any person wish to raise any issues about their safety they were provided with the means to do this if needed. A relative told us, "My [family member] is safe as they [staff] take them out and they always take great care to look after them."

Risks to people's safety and wellbeing were identified and managed, including those for behaviours which could challenge others. People were given the freedom and independence to determine what they did but they were kept safe whilst doing this. People were involved in decisions about their safety as much as practicable. One person showed us how they could access all areas of their home and that any risks or items which could cause potential harm had been removed.

Where any risk to people needed to be shared with external agencies, this was done. These risks included those for people to be able to eat and drink safely which were supported by the engagement of a speech and language therapist. We saw how people were helped by staff to be fed through a percutaneous endoscopic gastrostomy (PEG). This was for people who needed to be fed through a tube into their stomach to avoid any potential choking risks. One staff member described to us how people were supported with their nutritional and health needs. Records we viewed for people's nutritional and health care needs were completed by staff and accurate. This meant that people who needed these records would be identified as not eating or drinking enough promptly.

Staff checked the equipment people required before each time it was used. One staff member told us, "[Named person] has a special sling and if it was damaged I would contact the office to get a new one."

A sufficient number of staff were in post to meet people's assessed needs. One person communicated to us that they could "go out for a drive" when they wanted to with support from staff. One relative said, "[Family member] gets out and about and I have no reason to ever doubt that they are anything but safe." We saw that where people needed more staff to keep them safe then this was put in place, such as two staff for moving and handling people out of, or into, bed.

Staff continued to be recruited in a safe way with checks including those for previous employment and having a record which was clear of any criminal incidents. The recruitment manager said, "Involving people at interview helps us to check potential staff's suitability and if they could care for people we look after." Only suitable staff were employed and remained in employment.

People's medicines, including those which were administered as and when needed, were administered as prescribed and they were stored in a safe way. This was undertaken by staff who had been deemed competent to administer medicines' safely. People were only given medicines when they needed it. Regular reviews of each person's medicines were undertaken by their GP and any changes were implemented by staff. One staff member said, "I was checked by the [service] manager to make sure I gave each person their

medicine safely." People could be as independent as they needed to be with administering their own medicines.

Staff followed the provider's infection prevention and control policies and this included washing their hands and wearing protective clothing when needed.

Staff understood their responsibilities to report any poor standard of care should it ever occur. One staff member said, "I have never had a need to report any colleagues but I would if I had to. I know that [registered] manager would support me." Where incidents had occurred we saw that appropriate action had been taken to keep people safe. The provider took on-board learning from incidents to prevent them from happening again. They shared any potential learning with the staff team as well as the external stakeholders.

Good

Is the service effective?

Our findings

The process to assess people's needs and how these were to be met continued to maximise people's preferences. This helped promote people's social and religious needs. People were enabled to follow their religious beliefs and values. A health care professional told us, "We work with 'Next Steps' to achieve the best outcome for people that is possible. I see the difference this makes in the way some people who lived in hospital for many, many years are now living independently."

Staff when new to the service were given the training and support they needed including shadowing experienced staff members. This helped provide staff with the skills they required according to each person's needs. Subjects covered included diabetes awareness, PEG feeding, moving and handling; and infection prevention and control. One staff member said, "We do have training on many different things; some is face to face and some is e-learning. It depends on the person we care for." Equipment such as wheelchairs, lifting and hoisting and the adaptation of people's homes gave people the mobility they needed. People's independence was promoted and maintained by staff who knew how to do this.

People's nutritional needs were met by staff who supported them to eat and drink sufficient quantities of a healthy balanced diet. People could eat their favourite foods when they wanted and staff encouraged those people to eat healthily. One person communicated to us by smiling how much they liked a take-away. A health professional said, "[Staff] follow the guidance we give them to make sure people eat safely." People at risk of malnutrition were supported to achieve or maintain a healthy weight. People had the nutritional support they needed to help promote healthy living including low sugar diets or their foods cut up, or into, a size that met people's swallowing needs.

A pool of consistemt staff supported people over a period of time when they started to use the service. This helped people to adjust to their new home. The registered manager told us, "It's a massive change for young people. Never mind someone who may have only ever lived at home or in a hospital for many years." Staff enabled people to live the life they wanted and with freedom of choice.

People were supported by staff with accessing health care and were enabled to attend their appointments. A health professional told us how the staff had been successful in promoting a person's dental treatment by using a joined up approach and learning of what worked best for the person.

Staff understood the principles of the Mental Capacity Act 2005 (MCA). People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures to deprive people of their liberty for community are applied for through the Court of protection.

We observed that any restrictions on people's liberty were in the least restrictive way, such as only using the number of staff to keep them safe. People were assisted to make decisions about their care. They were supported to have maximum control of their lives and staff supported them in the least restrictive way possible. One person showed us how they could help with cooking and another person smiled after staff

had taken them out for a drive. We found that appropriate applications had been sent to people's social workers for those people who met the threshold to be lawfully deprived of their liberty. One staff said, "Giving people a limited choice helps as it reduces any confusion. I give them time but sometimes we can also prompt by saying or showing different options."

Good

Is the service caring?

Our findings

People were treated with kindness by staff and staff cared for each person in a way which made people feel they mattered. This was as well as using various different methods to communicate effectively with people including people's own sign or body language. One staff member said, "Most people we care for don't speak so we have to use their way to communicate such as touch, pointing to objects or giving them plenty of time." We saw that staff knew the people they cared for well and as a result they responded to people's needs with compassion. Staff used communication strategies based upon each person's abilities to enable people to have as much choice and control over their care as needed.

We saw that when assisting people, staff were considerate of each person's needs. For example, by making sure that equipment including that to help make people's sleeping as comfortable as possible, was positioned exactly how the person needed this to be. One relative told us that their family member had, "Blossomed as a result of staff's understanding of them since moving into their own home." People lived their life in a way they chose to. One person showed us their happiness by laughing with staff and smiling after just getting back from a drive to places they liked most. This approach by staff promoted people's independence and their wellbeing.

Relatives and external stakeholders we spoke with told us how they supported people who required some sort of advocacy. Advocacy seeks to ensure that people have their voice heard on all matters important to the person including having access to the same facilities as anyone else. People had their views genuinely considered when decisions were made about their lives. For example, to attend health care appointments and make decisions as a result of these. People could have as much or as little advocacy support as they wanted.

Staff described to us how they respected each person's privacy and dignity. We saw how people could, as a result of staff's support, watch their favourite sport on TV or read a favourite book in private. Staff described to us that as a result of the way their shifts were rostered that they had time for their training, time to spend with people and to provide care in a personal way. For example, by closing curtains and doors and covering people's dignity and respecting their privacy. Staff made sure that people were comfortable and responded to their needs when required such as if the person expressed any pain. One staff member told us, "Although some people can't speak with us, it is up to us to make sure they are independent but at the same time we avoid situations which could cause anxieties and then keep people as happy as possible." This demonstrated to us that people were supported in a caring and respectful way.

Good

Is the service responsive?

Our findings

People's care plans were detailed and they contained relevant information as a guide for staff. People contributed towards their care planning as much as practicable. This involvement was enabled by the provision of accessible ways to do this including sign language or objects of reference. Relatives or people's representatives also provided information that was used to form the basis of each person's care. This was about what was important to the person including a life history and their achievements such as going on holiday without staff for the first time.

The provider told us in their PIR, "Staff are matched with the people they are supporting through similar interests, cultural interests and religious beliefs." We saw that this was the case. One person showed us their football and other hobby memorabilia and how much they enjoyed these. We also saw how people's relatives had contributed towards enabling their family member to go dancing. People were treated equally by staff, no matter what their needs were.

People were supported to take part in a wide range of social stimulation such as going, swimming, to college, to an athletics track for wheelchair racing or making their own Christmas cards. For example, staff knew what people liked and they supported people to take part in day to day activities such as going for a drive or taking their pet for a walk. For some people, due to their disabilities, this was an incredible personal achievement and one which we saw they enjoyed. People's lives were transformed by staff who made a difference. For example, one person who had previously not been able to go out at all due to anxieties was now living an independent life. And, another person was being supported in applying to take part in a TV programme.

Where people used different communication methods including sign or body language, staff understood what the person was telling them and used their skills to help people communicate their wishes. Staff were also aware of people's individual triggers that could cause them some anxiety. This included staff supporting a person to avoid busy or noisy environments. Any urgent changes to people's care was communicated to staff using mobile phones and other electronic technology. This was as well as people being supported to go out in an electronic wheelchair or other mobility device.

People were given accessible ways to raise concerns. These included items which helped people with a sensory loss to share their concerns such as large print records and/or pointing to what the person was unhappy about. Concerns were acted upon by staff before they became a complaint. This was due to staff's in-depth understanding of the person and how to respond to their preferences in an individual way. Records of complaints showed us that these had been resolved in line with the provider's policies and to the complainant's satisfaction.

Policies and procedures were in place should any person require end of life care. Staff were knowledgeable about when any external health care support was needed such as for anticipatory medicines and pain relief. Relatives provided advice and guidance to staff about what their family member's wishes were. The service manager said, "Most people and their family members would need support on this sensitive subject and

using our knowledge of the person is a great help should the need ever arise."

Good

Is the service well-led?

Our findings

The registered manager led by example and they had fostered an open and honest staff culture which staff embraced. This culture was promoted through regular support to staff including induction, supervision, spot checks and staff meetings. One staff member told us, "I have never been so well supported in a job as I am in this one. It takes time to get to know people as their needs are complex. I can call the [registered] manager at any time and I am always given encouragement."

The registered manager also motivated their staff team with constructive feedback when things had not always gone as planned. For example, by using different staff or changing a staff's members role. And, putting measures in place to help make the quality of people's care as high as practicable. Staff worked as a team and we saw they helped each other to work well together.

Various ways were used to help get the best out of staff including meetings where staff were reminded of their responsibilities as well as being praised for what they had done well. We saw how one person who needed staff with a particular skill was enabled to be part of the community to take part in events such as swimming and sporting events. One staff member said, "I was checked up on only last week to make sure I was doing everything correctly. If we need additional support to help people go out more or to keep them safe we just have to ask." A health care professional told us, " [Staff] always work well with us, follow our guidance and tell us when things have gone well such as the person's nutritional support."

Various ways were used to include people, their relatives and staff as much as possible in having a say in how the service was run. For example, quality assurance surveys which showed that staff communicated with people well. One example of feedback from a relative was that staff understood their family member very well and gave them the best quality of life they could have. Records showed us the social stimulation people had received including going to a disco and to be able to access the community.

An effective programme of audits and quality assurance was in place. These audits for subjects including medicines' administration records were used to identify opportunities to make improvements. Staff were then reminded of their responsibilities to complete records accurately. We found that records including those for care plans were held securely.

People had many care needs which required external stakeholder interventions. People, as a result of successful implementation of recommendations from these stakeholders including the local authority Quality Improvement Team, led better lives. The registered manager kept abreast of any developments such as those for people living with autism and learning difficulties from national organisations. They then implemented these through forums such as staff training and development days. Any information about people's care was shared where this was required including with health care professionals such as a dentist. As registered nurses with the Nursing and Midwidery Council the registered manager and a representative of the provider kept their skills up-to-date and implemented any changes to people's care needs as a result of their knowledge.