Heritage Care Limited

London & South East Domiciliary Care Branch

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

About the service
London & South East Domiciliary Care is part of Heritage Care. The service provides personal care to people living in their own home on a 24-hour basis.

At the time of inspection, the service provided care for people living in shared accommodation in Brighton & Hove and three London Boroughs. People lived in local authority and private housing, with some being purpose-built and divided into flats. Each flat or house provided living accommodation for one person to five people. At the time of inspection, the service was caring for 37 people.

People's experience of using this service and what we found
The service supported people with a learning disability, autism and complex health needs. The outcomes for people using the service reflected the principles and values of Registering the Right Support by promoting choice and control, independence and inclusion. People's support focused on them having as many opportunities as possible for them to gain new skills and become more independent.

Relatives of the people using the service were happy with the care being received. One relative told us, "I can't fault them, they [relative] are happy, the staff know their [relative's] ways." Another said, "In three years, [relative] has come on leaps and bounds, they are more independent because of the input by the care staff."

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Care plans were holistic and written in large print with pictures in an easy read format, enabling the person to contribute to their plan of care.

The service followed safe staff recruitment processes. Staff were appropriately trained to meet the needs of the people using the service including safe handling of medicines. Systems were in place to monitor safe delivery of care through audits, observational supervision and senior management oversight.

The service worked in collaboration with health and social care professionals and across several local authorities to provide joined-up care. A complaints process was in place and people knew who to go to if they were unhappy with the service.

People were encouraged to be involved in activities within the local communities and these were person-centred. Some people attended local colleges, undertook voluntary jobs, attended places of worship, as well as a variety of local activities. Music and dance were appreciated by many of the people using the service and some people had performed with professional theatre and ballet companies.

People were supported to shop for groceries and healthy eating was encouraged. At some of the houses, meal times provided an opportunity to meet up and prepare, cook and eat together. The varied abilities of the people using the service were understood by staff, and people were assisted to reach their full potential. We observed the promotion of equality and diversity and staff treating people in a respectful and dignified manner.

Information about some people's end of life wishes had been recorded. However, staff may not be able to support someone at the end of their life as training had not been provided.

We have made recommendations that the provider sources end of life training for staff.

The service was well led by an experienced management team. Quality assurance practices were in place to monitor the service to ensure it delivered high quality care to people.

Rating at last inspection: The last rating for this service was Good (published 22 December 2016).

Why we inspected
This was a planned inspection based on the previous rating.

Follow up: we will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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.
Details are in our Safe findings below.

Is the service effective?

Good

The service was effective.
Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.
Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive.
Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led.
Details are in our Well-led findings below.

London & South East Domiciliary Care Branch

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of one inspector and one assistant inspector

Service and service type
London & South East Domiciliary Care is a domiciliary care agency. It provides personal care to people living in their own houses, flats and specialist housing.

The service was managed by team leaders and care staff, with oversight by two registered managers and one regional manager. The two managers were registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

The inspection site visit activity started on 26 June 2019 and ended on 19 July 2019. This included visiting the office location on 28 June 2019 and 01 July 2019 and people in their own homes on 03 July 2019.

What we did before the inspection

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We spoke with seven people who used the service and gained feedback about their experience of the care provided. People used a range of different communication methods including vocal and body language. We spoke with three team leaders, eight care staff members as well as the two registered managers and the regional manager.

We reviewed a range of records. This included eleven people's care files and medicine records. We looked at eleven staff files in relation to recruitment, supervision and training, and a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance questionnaires and spoke with five relatives and one health care professional.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same.

People were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse
• Staff could demonstrate understanding of adult safeguarding procedures and how to report an allegation of abuse. A staff member told us, "I would go to the team leader or support manager if I was concerned." Relatives were confident that if they had any concerns they would be dealt with appropriately by the management team.
• Staff had received training in adult safeguarding, with managers having undertaken advanced safeguarding training.
• Systems were in place to safeguard people including policies and guidelines on safeguarding and whistleblowing.
• People using the service were provided with an easy read service user guide which contained contact details of senior personnel, if they had any concerns.

Assessing risk, safety monitoring and management
• Care plans showed risk assessments were carried out which identified potential risks and action taken to minimise them.
• The person-centred care plans identified the most appropriate action to take to de-escalate different situations. The risk assessments also looked at how one person's behaviour affected others living in the same accommodation.
• Quality assurance audits were in place to monitor areas such as falls, incidents and medicines. The service had introduced a system where audits across the service were reviewed by different team leaders which provided a fresh view of people's care, as well as the sharing of good practice. Team leaders were positive about these changes.
• The service received oversight monitoring by senior management. The registered managers had their own areas to oversee and conducted regular visits. The regional manager reviewed risk assessments and visited the service frequently.

Staffing and recruitment
• Staffing levels were maintained in line with people's care needs.
• Safe staff recruitment procedures were followed which included making the necessary checks to ensure staff were suitable to work with vulnerable people.
• Team leaders expressed the importance of having regular staff to meet the complex needs of the people using the service. This was echoed by one relative who told us that their relative was now more settled with stable staff. In the event of agency staff being called upon, where possible the same staff were used to

maintain continuity.

Using medicines safely
• Staff received medicines training. Observational supervisions were carried out for medicines administration to ensure ongoing staff competency.
• Risk assessments for administration of medicines were in place, with guidance for staff on how risks were minimised. A list of medicines and how to take them, including self-administration where appropriate, were clearly documented on the computerised care plan. This included consent and to meet individual needs, for example one care plan read, "I like to keep to my daily routine, having my shower and then my medicines."
• PRN (as required) medicine records contained clear guidance on when they should be administered.
• Staff had received training in Epilepsy and medicine administration specific to this condition and a course in supporting people with learning disabilities in how to take their medicines.

Preventing and controlling infection
• Staff received training on infection control procedures and the appropriate use of personal protective equipment (PPE) to prevent the spread of infection.
• Staff confirmed they were supplied with enough gloves and aprons to carry out their work safely.

Learning lessons when things go wrong
• The regional manager highlighted some recent incidents and the actions taken in response to these. They explained how, when incidents occurred, lessons learned were shared at management meetings. Actions from those were shared with staff.
• The regional manager met regularly with the board of directors and discussed where improvements could be made.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same.

This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• There was a holistic approach to assessing, planning and delivery of care, which took into consideration the person's mental, physical and social wellbeing.
• Care plans were very detailed, including 'My Life Story' which provided a social history. The care plans were written in the first person, for example, "I like to make my own breakfast and have a cup of coffee in the morning." This showed that what was important to the person, was clearly identified. The care plans also promoted the person's likes and dislikes.
• A health action plan, which was reviewed six-monthly, included regular health check-ups specific to the individual, for example one read, "I need foods which are nutritious and balanced, and I need support from staff."
• Relatives were confident in the abilities of the staff and felt their relative was safe using the service. One relative said, "[Relative] is settled in the home as I can tell from their body language. I would know if they were unhappy."

Staff support: induction, training, skills and experience
• Newly appointed staff received an induction in line with the Care Certificate standards. The Care Certificate is an identified minimum set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in health and social care. This consisted of formal training, practical and shadowing experienced staff. One staff member told us, "I am learning through doing my care certificate then I want to do my Quality and Credit Framework (QCF) Level 2 in care. The team leader is really nice and is supportive."
• Staff training records showed that a variety of courses were offered such as autism, which was in addition to the mandatory subjects. Learning and development of senior personnel included courses in management topics, to ensure they were competent in overseeing staff practice.
• Staff received supervisions and appraisals. Team Leaders attended meetings with the registered managers, which gave them an opportunity to share knowledge.

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported in different ways with their meals and independence was encouraged. Some people were assisted by staff with the purchase of groceries and preparing and cooking meals.
• People who lived with others, worked together to prepare and cook the meals, with oversight by staff. A team leader told us that one person was too apprehensive about helping with meals in the house they shared when they first joined the service. With patience and encouragement, they now helped lay the tables

and with clearing away after the meal. The staff member explained what a big achievement that was and that everybody contributed in some way within their capability.
• Risk assessments were in place for specific conditions such as dysphagia (difficulty in swallowing). Referrals were made to the speech and language team (SaLT) and clear guidelines had been obtained for staff to follow.
• In the kitchen of one person's home we visited, we saw a notice board with pictures of different meals and information on nutrition. The registered manager informed us that the provision of the visual presentation of meals, assisted people who were more visual with their communication to make a choice with meals.

Staff working with other agencies to provide consistent, effective, timely care
• People at the service had a 'hospital passport', which contained full details about them, including their medical history and care needs. This was in an easy read format. The 'passport' provided useful information for shared care with the hospital staff should the person receive admission.
• In the event of an emergency or non-anticipated health matter, people would either attend their GP practice or hospital. The registered manager informed us that staff were proactive in seeking assistance from health and social care professionals for people's health needs.
• One professional told us they were asked for their advice and assistance with people's needs in a timely manner and visited people often.

Adapting service, design, decoration to meet people's needs
• People were encouraged to decorate their rooms to their own preference when living in shared accommodation.
• Where possible, the service supported people to adapt their environment to ensure it met their needs.

Supporting people to live healthier lives, access healthcare services and support
• Staff had an in-depth knowledge of the people they were caring for and spoke with genuine interest and passion when discussing their care and support needs, including suggestions on different activities which people might enjoy.
• People were supported to access healthcare services such as the GP or dietician, to gain advice on living a healthy lifestyle. For example, we saw in one care plan, that the person was receiving weight reducing advice from the local GP.
• Care plans viewed contained information on health appointments such as the dentist. In one care plan handwritten notes from the GP provided written instructions for staff. This ensured that the doctor's instructions were clear to all staff and people were kept well.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, the DoLS cannot be used. Instead, an application can be made to the Court of Protection who can authorise deprivations of liberty.

• Assessments of people's mental capacity to make their own decisions had been completed. Where they were unable to make their own decision, applications to the Court of Protection had been made to protect their rights. It was noted that some of these were not up-to-date and were due for renewal, however the registered manager was in the process of updating these.
• Where people indicated they needed support around some level of decision making about their health and welling, this was clearly indicated how staff should support them to do this.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• Staff showed compassion when talking about their role in caring for the people using the service. Staff told us, "It is important that all people using the service are safe and comfortable." Staff members referred to their roles as, "Feels like we are part of a family, I treat people as I would my own" and "I feel like I am going to my 'other' family." One staff member told us, "I'm happy working here, we are helping someone live a happier life."
• We observed staff treating people in a caring manner, with good interaction between them. Staff were attentive to the needs of the individual and included them in conversations.
• People were supported to attend religious or spiritual meetings that included prayer and social activities. This support enabled them to continue with areas of their lives which were important to them. For those unable to attend, visits by the relevant religious or faith leaders from the local community were arranged.
• Equality and diversity were at the forefront of the service and met with the Equality Act 2010. The service recognised organisations that supported diverse communities and promoted a 'living without fear of discrimination' culture. People's religious, cultural and lifestyle choice were respected. These were identified in the care plan, with information on how to support them, including maintaining relationships.

Supporting people to express their views and be involved in making decisions about their care
• Staff established the views of people through their preferred method of communication. The body language reaction of one person to activities was discussed and it was established that the person did not appear to like certain activities that were noisy, and they were more settled during quieter activities. This showed that staff knew the people they were caring for well and explored ways to ensure people expressed their views.
• Information about the service or the care needs of the person was presented in a format that met the individual person's communication needs.
• Relatives were active in their relative's care needs and assisted as advocates in the decision-making process. Advocacy seeks to ensure people have their voice heard on issues that are important to them.
• Quality assurance questionnaires were given to people, relatives and staff to enable management to establish their viewpoints. Comments included, "The way staff support me is very good" and, "Continue with promoting independence and choice." We also saw feedback forms from Trustee visits which were positive.

Respecting and promoting people's privacy, dignity and independence

• A culture of promoting ability and what people can achieve was demonstrated. One person told us, "I'm happy here. I cook and I clean my room. I work one day a week which I enjoy." Another said, "I like to make my own breakfast and have a cup of coffee in the morning."
• Staff were familiar with the needs of the people. We observed people being treated with privacy and dignity by staff when they had to attend to care needs. People were assisted back to their bedroom and the door was closed ensuring any care practices were carried out in private.
• The team leader arranged for us to speak to one of the people and asked them for their consent, which ensured their agreement was obtained.
• Care plans showed that people were supported to live as independently as they were able. One relative told us, "My [relative] has come on so well socially." Another said, "My [relative] has become more independent because of the input of the staff."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same.

This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences.
• The service kept in touch with people's relatives through telephone calls and e-mails. This ensured that any concerns or needs of the person were responded to quickly. Relatives told us, "Our [relative] was unwell. It was handled well, and we were informed." Another said, "They [staff] always let me know if my [relative] is unwell."
• Care plans were comprehensive and provided current information on the people's care needs. They were person-centred and appropriate. One support plan showed where the service and hospital consultant had worked together to provide a best interest decision around the person's medicines administration.
• The registered managers were available for staff to consult with if they had a concern. Staff confirmed senior management visited regularly.
• The service supported people to go to various social and leisure interests, including swimming, nightclubs, music, dance venues and local colleges.

Meeting people's communication needs: Accessible Information Standard (AIS).
The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• All documentation and information presented to people using the service was in an easy read format with large print and pictures or photos.
• For those whose first language was not English, attempts were made by the registered managers to meet their cultural needs. For example, a team leader was assigned to one person who spoke the same European language but with limited English. This allowed for positive communication which provided the person with more confidence. Visits to their local cultural shop to gain specific familiar foods and DVDs in the European language were very positive for the person.
• Care plans were clearly documented in depth about how the person communicated. One very detailed communication passport read, "What does [person] like and how do we know? What does [person] dislike and how do we know?" The care plan provided staff with information on the best way to communicate with the person including the most appropriate time and place. For example, non-verbal gestures or the use of Makaton sign language.
• How people communicated varied and included smiles and focused eye contact. Staff interacted well with people for example, one person had returned from college and staff asked them if they had a good day and they responded with smiles and hand gestures.

Improving care quality in response to complaints or concerns
• Complaints were recorded and analysed. They were reviewed monthly and a summary presented to the Board to establish if there were any themes
• Complaints were responded to in line with the complaints policy and procedures. Where necessary, notifications were sent to the Care Quality Commission to meet the registration requirements. When a complaint was received at the head office, it was sent to the relevant team leader for their response.
• People, their relatives and staff were provided with information on how to make a complaint or raise a concern. Staff and relatives were confident that should they raise a complaint or concern, it would be dealt with appropriately. The easy read service user guide contained contact details of those to report to in the event of a complaint.

End of life care and support
• At the time of the inspection, no one was receiving palliative care.
• From the care plans there was some reference to end of life care wishes.
• The registered managers told us about end of life arrangements. They recognised that, in the event a person using the service being diagnosed with a terminal illness and chose to remain at home, there must be a system in place to meet their needs and wishes. The registered manager told us they were in the process of producing an end of life pack in easy read format to enable the staff to discuss end of life wishes with people and their families.
• Records showed that staff had not received training in end of life care.

We recommend the provider sources end of life training for staff as good practice, and as part of the end of life plans already being produced by the registered manager.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same.

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The team leaders promoted an open, positive culture which put the people at the heart of the service.
• People received person-centred care. Interests were pursued. One person particularly liked the theatre and ballet and the staff arranged for them to join a professional ballet company, linked with local theatres which enabled them to perform on stage as part of the cast.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• Senior managers were knowledgeable and skilled to provide oversight of the service.
• The management team fully recognised and understood duty of candour and their legal responsibilities through an open culture. One staff member told us, "They [regional manager] told us there is an open culture and to tell them if something was wrong, so I would."
• The regional manager told us the management team had responded to complaints and incidents by being more hands-on and leading by example. Staff confirmed that senior staff were visible and active at the service providing support and advice.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The two registered managers spoke with compassion and enthusiasm about the care provided to the people using the service and about supporting the staff. The registered managers told us how proud they were of the staff as they were committed to providing person-centred care.
• Staff were clear about their roles and the expectation of the service in maintaining a high standard of care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Staff supported people to be engaged and involved in the service. For example, one person required specific assistance to complete small but important tasks. A team leader told us, "With active support the person began to learn new things. I feel proud to have helped them with their achievements."
• The computerised care planning system was inclusive. We were shown photographs of activities and events people attended as well as their support needs. The system allowed for visiting professionals to

document their findings and any instructions for staff to follow.
• The team leader told us that families were involved. They gave an example of one relative who liked to receive photographs monthly, as it was their way of being able to be in touch.
• The service had strong links to the local communities. People were involved in the theatre, cycling, food for life courses, yoga, music and dance sessions. One person who attended the local college was going to attend a Prom night and the staff spoke with them about the outfit chosen.

Continuous learning and improving care
• Staff were positive about the training they received. There was a clear career pathway.
• Staff meetings were carried out. Each staff member was given an opportunity to contribute with ideas, and these were discussed.
• Achievements by staff were recognised by the company with a Reward and Recognition scheme, which was promoted through newsletters. The newsletter also contained information on the service and any changes to practice which provided staff with current knowledge.

Working in partnership with others
• The service worked closely with the different local health and social care authorities. One team leader told us, "The local authority is very supportive. They provide training on different topics for the local area and we attend those relevant. They are so helpful, if I had a query, I can ring them, and they will help me."
• The team leader told us that relationships with local amenity organisations were important, and they were active in exploring new ventures and increasing links with different activity providers. The registered managers told us, "We are proud of the people using the service and staff. We are always looking at how we can stimulate people with new activities to help move them on to more experiences."