Wandsworth Borough Council

KITE – Keep Independent Through Enablement

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

KITE – Keep Independent Through Enablement provides short term assessment and enablement services to people in their own homes to help them be as independent as possible. The service is for people who have been discharged from hospital or whose health has deteriorated.

At the last inspection, the service was rated Good.

At this inspection we found the service remained Good.

There was a registered manager at the service. 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 using the service told us they felt safe in the presence of care workers. They praised them for their caring attitude and said they felt their wishes were respected and they were offered a choice. People were supported to regain their independence and each person had enablement plans which documented the goals that had been agreed with them. They said that care workers helped them to achieve their goals.

There was an emphasis on dignity in care at the service. The registered manager had been involved in running some workshops around dignity in care and was an active supporter of the campaign and had encouraged staff to become dignity champions. Care workers demonstrated passion and a real empathy for people when talking about how they ensured people were treated with dignity and respect.

Thorough assessments were completed when people had been referred and accepted into the service. These assessments were carried out by an enablement officer and an occupational therapist. Risk assessments were completed for people which included ways in which potential risk could be managed, any aids to support mobility or independence were identified and a care plan agreed with people.

Appropriate pre-employment checks were completed for new staff which helped to ensure they were suitable to work with people. New starters completed the Care Certificate as part of their induction and thereafter received annual mandatory training which helped to ensure their skills were up to date. Staff received regular supervision and yearly appraisals.

People were given information about how they could complain if they had concerns. Where complaints had been raised, these were recorded and responded to them in a timely manner.

Feedback was sought from people at regular intervals during the time they received a service. People were also able to feedback at the end of their support as part of the provider's quality assurance monitoring. Other monthly audits took place looking at a range of areas including complaints, training and quality of

record keeping which helped to maintain good stands.

We received positive feedback from people using the service. The registered manager was approachable and was receptive to initiatives to try and improve the service.
The provider worked in partnership with a number of agencies which helped to ensure people received appropriate support.

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 remains Good.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The service was Good.

The provider worked closely with health professionals and other and other organisations.

Processes were in place to see how the service could be improved.

The registered manager was involved in a number of community initiatives in relation to the wellbeing of people.

KITE – Keep Independent Through Enablement

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 was a comprehensive inspection and took place on 19 December 2017.

The inspection was announced, the provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

The inspection was carried out by one inspector. An Expert by Experience spoke with people using the service and their relatives by phone after the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses older people care services.

Before the inspection, we reviewed the information we held about the service. This included notifications sent to us by the provider and other information we held on our database about the service. Statutory notifications include information about important events which the provider is required to send us by law.

During the inspection we spoke with the registered manager, a care co-ordinator, an enablement officer and three care workers.

We checked records related to the management of the service. These included five care plans, four staff files, training records and audits.

After the inspection we spoke with seven people using the service and two relatives over the phone. We also received feedback from two health and social care professionals.

Good

Is the service safe?

Our findings

We asked people using the service and their relatives if they felt safe in the presence of care workers. They told us, "Totally safe, they are obviously well trained", "Yes, never been a worry to me at all", "Yes, I feel safe with them" and "Always feel safe with them."

Care workers were aware of safeguarding procedures and the steps they would take if they suspected a person was at risk of harm. They told us, "Safeguarding is making sure people are safe from harm" and "I would observe and look for signs that they are not themselves, or unkempt or even signs of bruising." Training records showed that safeguarding training was delivered on an annual basis.

People using the service and their relatives did not raise any major concerns with the time keeping of care workers, telling us, "No they have always turned up not always according to the timetable", "They aren't usually late by much", "They always turn up, they come every day for a visit", "They come within a reasonable time, someone always comes", "They always come but timing is very variable", and "Someone always comes, they are very reliable."

One care worker told us, "We get our rotas so we know what visits we have for the coming week." There was an electronic monitoring system set up to send alerts if a care worker had not logged in on a visit which was then chased up by the care co-ordinators. The system was also set up to email details of any missed or cancelled visits which were then chased up by the care co-ordinators. There were two out of hours staff available in the evening until 22:00 when the service stopped. They completed an out of hours log with details of any incidents or issues occurring during that time.

The provider had robust recruitment procedures in place. Staff files contained evidence of the necessary pre-employment checks such as right to work, identity and references. A care worker told us, "I had a face to face meeting and I had to bring in all my certificates and proof of ID." Each staff member had a current Disclosure and Barring Service (DBS) check. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions.

Different risk assessments were completed during the initial assessment which helped to ensure people were kept safe. These included a medicines risk assessment, a generic risk assessment, a bathing/showering risk assessment and a manual handling risk assessment. These identified any areas of risk and control measures needed to manage and minimise the risk. The assessment was a joint visit carried out by an enablement officer and an Occupational Therapist (OT) so that all areas of risk could be suitably identified at the initial visit. The OT focussed on the functional side of the assessment looking at whether any aids or equipment were required. An enablement officer told us, "We go and see the clients after they come out of Hospital and assess them on their safety and mobility" and "We ask the clients to do their daily tasks and make sure they are safe. An OT will look at any equipment needed and make any referrals."

Staff told us they did not administer medicines for people. There was a medicines risk assessment that was completed for people during the initial assessment to ensure they were able to manage their own

medicines, either themselves or with the assistance of family or friends. If the assessor found that people were not able to manage their own medicines then a referral was made to the district nursing team or the longer term support team. People told us they managed their own medicines, comments included "I take my own tablets but I make sure I do it when they are here", "I take my own, have for the last 20 years" and "I don't need help with medicines."

Good

Is the service effective?

Our findings

People using the service were supported by staff who received regular training to enable them to meet people's needs effectively.

Care workers told us, "The training is excellent, we get a portfolio so we can reflect back on what we learnt", "I had a full induction when I started" and "Our supervisions are reflective looking back at any issues or concerns."

New staff completed the Care Certificate as part of their induction. The Care Certificate is an identified set of 15 standards that health and social care workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers and was developed jointly by Skills for Care, Health Education England and Skills for Health. Care certificate observations and assessments were seen in individual staff files.

Mandatory training included manual handling, medicines, first aid, infection control, health and safety, safeguarding, dignity in care, enablement refresher, fluid and nutrition and was refreshed annually. A training matrix was maintained highlighting when care workers completed their training and when it was due. We saw evidence that where training had expired, this had been booked for them to complete.

Supervisions were held every six to eight weeks and a spreadsheet was maintained to keep track on when care workers had their last supervision. We looked at supervision records and saw they included discussions around safeguarding, record keeping, training and development and wellbeing.

Staff also received yearly appraisals in which they agreed objectives for the coming year and evidence of how they were demonstrating value and behaviours of the organisation.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager told us only people with the capacity to consent and agree to the support provided were eligible for the service. Assessments and care plans were signed by people using the service indicating their consent. We asked people if they had been involved in planning their care and if they had a copy of their care plan. They said, "[My relative] and I decided that we didn't need them to come four times a day and have reduced to three visits a day. Yes we have a copy", "I helped decide what I needed", "Yes, we planned what I needed together and I have a copy" and "I had a say in what was needed."

Care workers told us, "We have to encourage them to make decisions", "All the clients have to have capacity and agree to the enablement program" and "We get consent during the initial assessment and people often request for any family or friends to be present."

We asked people and their relatives if they received appropriate support with meals. They said, " My [relative] is pretty independent and doesn't much like them in the kitchen", "Yes, they often make me lunch but not always, they always offer", "Snacks and drinks sometimes but I can make my meals", "No I can do my meals or my [relative] comes every day", "I have friends who cook things and put them in the fridge and then the carers heat them up for me, this works well" and "They make porridge in the morning which is more than I expected they would do and they give meals at the two other visits."

People were supported to maintain good health and had access to appropriate healthcare professionals if needed.

The registered manager told us that a thorough assessment was completed so that a holistic approach was taken looking at people's eyesight, hearing, nail care and oral care. She explained that this was done so that appropriate care could be delivered and referrals made to relevant professionals such as opticians, audiologists or dentists if required. The initial assessment was carried out with an Occupational Therapist (OT) so that the relevant mobility aids could be ordered and referrals made for extra support if needed.

The majority of referrals were for support after a stay in hospital, so details about people's hospital admission were included in the referral forms which helped care workers to support them appropriately. Contact details of GPs and other appropriate professionals were also documented in care plans. The registered manager said, "We speak with the district nurses but also signpost to other services such as blind and deaf services."

Good

Is the service caring?

Our findings

People using the service praised the caring attitude of staff. Comments included, "They are fantastic I can't fault them, always friendly and helpful", "Really very good, I can't complain at all", "I can't praise them too much", "They are all very good", "Always polite and caring", "They are polite but quite jolly", "They have become my friends and as I get better often they just chat with me" and "They are wonderful kind ladies."

People told us that care workers respected their choices and gave them freedom to do so. We asked them to give us some examples of where care workers had demonstrated this. They said, "Definitely, they all call me by my Christian name which seems right when they are giving me a shower and things", "They let me choose what I do and what I need", "They are really good like that, for example they thought I ought to go to a lunch club, and when I said I didn't like the idea they dropped it", "They don't make me do anything I don't want to do", "Yes, they allow me to choose what I wear and what I do" and "I told them I like a small lunch and my proper meal later and they have gone along with that."

Care workers respected people's privacy and dignity. "All my shower and changing of bag (urinary catheter) is always discreetly done", "They treat me with respect and when I have my leg dressed it is always private though I live on my own", "They do give me privacy and they make the things that are not dignified easier", and "They treat me as a person and make me feel cared for",

The registered manager had signed up to the Dignity in Care Council which aims to put dignity and respect at the heart of UK care services. Care workers were aware of the importance of respecting people's privacy and dignity and gave us examples which demonstrated how they did this. They demonstrated passion and a real empathy for people when talking about how they ensured people were treated with dignity and respect. They said, "It's important to me to make sure people have their dignity met", "Everyone has different needs and you have to meet everyone's individual needs", "I ask them if they can manage and if you need me, I am here for you", "I'm proud to be a dignity champion", and "I always introduce myself and explain why I am there because I'm a stranger going into their home."

The provider promoted people's independence. Care workers were aware their role was to try and encourage people to regain some level of independence. A care worker said, "Most people want to gain their independence and we have to help them and encourage them to engage." An enablement officer said, and "Care workers need to encourage and enable people to do things such as meal preparation themselves as much as possible."

The provider was sensitive to people's diverse and cultural needs. Care worker said, "We ask about religious and cultural requirements as it could have an impact on how we deliver care" and "We treat them as individuals and listen to them." The registered manager told us that care plans were available in larger print, braille and also other languages.

The registered manager told us they often referred people to community social schemes if they were assessed as needing social support or expressed they were lonely so they could receive support in this area.

Good

Is the service responsive?

Our findings

A thorough assessment procedure was in place which helped to ensure the service was appropriate for people.

The registered manager told us about the referral process for new placements. The maximum length of the term for enablement was six weeks, with the usual turnaround time being four weeks. She told us that 90% of the referrals came from St Georges Hospital and 10% from community teams linked to local GP surgeries. Once a referral had come through, it was screened by the care co-ordinators and once accepted given to an enablement officer to arrange a meeting with the person and complete a care needs assessment and other risk assessments. This was a joint visit carried out with an Occupational Therapist who carried out functional test and identified potential mobility aids to further support people.

The OT also completed an enablement plan. These were devised at the time of the initial assessment and identified clear goals for people to achieve during their time with the service. The purpose of this was to help people regain their confidence and independence with their daily living skills which they had lost during their stay in hospital. Goals were clearly identified and set so they were achievable within the time frames of the service and included ways in which care workers were to encourage people's independence.

The provider worked in close partnership with a local wellbeing centre to help people achieve their goals. The centre had a gym and was able to provide a range of programmes such as exercise, cookery and IT. The registered manager told us, "We work closely with Randall Close [wellbeing centre], we refer to them for exercises and cooking and even social." People were given the option to use this service and those that wished to take the offer were referred to the centre. We contacted the day services manager of this service who gave us very positive feedback in relation to the close working partnership that had been established and also the support that was offered to people using the service.

Enablement plans were reviewed on a regular basis, after 10 days, three weeks and the end of the service. People told us, "It has been updated once already since I came out of hospital", "It has been changed quite a lot, quite often as progress is being made" and "I've have had the visits for 3 weeks now and I think we have reviewed more than once."

Each person received a copy of the care plan, a booklet about the service and how they could make a complaint. People said, "I have never wanted to complain but I know what to do if I had to", "I haven't needed to make a complaint, but I certainly would do so if I needed to", "I have no concerns" and "I haven't made a complaint." A staff member told us, "People will often tell us if they are not happy during the reviews and we have to then investigate further."

All complaints went through to the central complaints team. Since January 2017 there had been nine formal complaints. Each complaint had a complaint action and resolution plan which contained details of the complaint and the outcome. The registered manager told us, "We will always arrange to see the client face to face to discuss their concerns." We saw evidence that the provider took action on complaints received, for

example bringing care workers in for extra supervision or asking them for feedback.

Good

Is the service well-led?

Our findings

People using the service told us, "They vary a bit, but overall excellent", "Wonderful people, don't know what I would have done without them" and "A good service overall." A newsletter was also distributed to people using the service keeping them informed of any news in relation to the service.

Care workers told us they enjoyed their role and felt well supported by the registered manager. "My job is very important to me. I'm very passionate about it", "[The registered manager] is brilliant, she makes sure we have regular training and supervision. If we are not clear on anything, we can go to her anytime", "[The registered manager] is amazing, any problems her door is always open", "Our motto is everyone has the potential for enablement" and "We all work really well together."

The registered manager was supported by a team of care coordinators who were responsible for doing the staff rotas and scheduling visits and enablement officers who carried out the initial reviews. A team of care workers visited people to support them to achieve their goals. The service was therapy led and there were occupational therapists (OT) and a senior social worker on the team. Joint visits were carried out by an enablement officer and an OT. The registered manager told us they worked very closely with health professionals during the assessment period and had established close links with the other teams such as the MIT (Maximising Independence Team), nutrition teams and other organisations. They had also established links with the London Fire Brigade if any help was needed in relation to smoke detectors.

Health professionals fed back that they had a very close relationship with the service and found them to be receptive in developing new and innovate ways of promoting health and wellbeing. One comment was, "I would like to truly commend [the registered manager] for their tireless commitment to putting people and their wellbeing at the very heart of what we do. I can see at first hand the profound impact this programme is having on hundreds of people." They added that "In almost all of those people who have come through this programme have better mobility, and psychologically feeling so much better that they are still living in their own homes" and "We are also now running speech and language groups for those people who have acquired strokes. All of the staff from KITE has worked within our unit within our gyms to have an innate understanding of maximising independence."

Initiatives were in place to see how the service could be improved. The registered manager told us they had done work over the past two years to streamline many of the processes. She told us that many of the workflows used to be paper led but these had been developed so they could be tracked electronically. She also told us they were looking at ways of carrying out their care needs assessment on mobile devices so these can be completed in real time. The provider was piloting a new scheme to try and reduce the time it took for referrals to be accepted. This consisted of having an OT based in the hospital who sent through referrals that were pre-screened resulting in less time for referrals to be accepted and also ensuring the right type of referrals were coming through.

The registered manager was a member of the Dignity in Care Council and had started a dignity in care campaign in Wandsworth, which aims to put dignity and respect at the heart of UK care services. The goal

was to sign up all staff up to the campaign and increase awareness of dignity in care. As part of this, an event had been held in January 2017 where people were invited to share their ideas about how dignity can be at the heart of the care given to the borough's most vulnerable residents. Following on from this dignity in care workshops were held that allowed people to exchange thoughts and ideas, and those who attended were later invited to sign up to be Dignity Champions. The registered manager told us all her staff were asked to join this campaign and commit to the dignity in care 10 point challenge.

The registered manager told us the service was actively involved in the 'keep well, keep warm' scheme to support people to stay warm during winter. She gave an example where a person came out of hospital and their heating was not working. They were provided with heaters, blankets and supported with hot meals during this time. The service retained a list of people that had previously used the service but were still vulnerable. The provider made welfare checks on these people to ensure they were OK.

Quality assurance and governance systems were effective and used to drive continuous improvement.

A regular system of review was in place which helped to ensure people were satisfied with the service or of if anything needed amending. A review was done after ten days after the initial assessment and thereafter after three weeks. A final review was done after five weeks or close to the end of the term of the support plan. During this final review people were asked about any ongoing support they would potentially need after their term with KITE ended. Feedback surveys were completed when people finished receiving the service. People were asked if care workers were polite, if their goals had been met, if they received a good level of service. We reviewed some of the questionnaires and saw a number of positive comments from people about the service.

A KITE performance and QA including the number of referrals, safeguarding, complaints/compliments, quality assurance checks, quality of care notes, supervision and training was also completed. Each area had an action plan if required which was followed up on the next monthly report. This was shared with the assistant director and also the quality board for greater management insight. The registered manager met with the social work team manager on a monthly basis to look at the discharges. There was an action plan in place with some of the points including future dignity in care council workshops, a single assessment tool, changes to the risk assessments, joint working with other agencies.