Affinity Trust

Affinity Trust - Domicilliary Care Agency - Southend and Essex

Inspection report

Suite 7, First Floor
Chalkwell Lawns
Westcliff On Sea
Essex
SS0 9HR

Tel: 01702335980
Website: www.affinitytrust.org

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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 undertook an announced inspection of Affinity Trust - Domiciliary Care Agency Southend and Essex on 30 November, 5 and 8 December 2017.

The service provides care and support to people with physical disabilities, learning disabilities and/or autistic spectrum conditions, living in supported living settings such as shared or self-contained accommodation. Supported living accommodation enables people to live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living. This inspection looked at people's personal care and support. At the time of our inspection, 34 people were being supported by the service.

There was a registered manager 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.

At our previous inspection in July 2016, we rated the service 'Requires Improvement'. We found the service in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because not all staff had been provided with specialist training to enable them to have the correct skills and knowledge to provide effective care to people. At this inspection we found improvements had been made and the service was no longer in breach of this regulation.

The service embraced the principles that underpin the 'Registering the Right Support' and other best practice guidance; these include choice, promotion of independence and inclusion. The registered provider was signed up to the Driving Quality Code to drive up quality in services for people with learning disabilities that goes beyond minimum standards. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

Although the service had systems in place to assess the quality of the service provided, improvements were required to some areas of quality assurance to ensure record keeping was consistent and to a good standard. We have made a recommendation in relation to the quality of record keeping.

People were safe. Staff understood their responsibilities in relation to safeguarding and received relevant training. There were systems in place to notify the appropriate authorities where concerns were identified. Where risks to people had been identified risk assessments were in place and action had been taken to manage these.

Risks to people's health and wellbeing were appropriately assessed, managed and reviewed. Staff were aware of people's individual needs and followed guidance to keep them safe. People received their medicine as prescribed. The service had safe recruitment processes and there were sufficient numbers of

staff to meet people's care and support needs.

Staff had a good understanding of the Mental Capacity Act (MCA) 2005 and applied its principles in their work. The MCA protects the rights of people who may not be able to make particular decisions themselves.

People were treated as individuals by staff committed to respecting people's individual preferences; the service's diversity policy supported this culture. Care plans were person centred and detailed people's preferences and the outcomes they wanted to achieve. People were supported to maintain relationships with friends and families and encouraged and supported to pursue their hobbies and interests. A complaints policy and procedure was in place and information on how to raise any concerns or complaints were available in alternative formats such as pictorial and large print.

The registered manager demonstrated strong values and commitment to learn and implement best practice, ensuring people had a good quality of life. Staff were motivated and proud to work at the service and were positive about the support they received from management. Staff supervision and meetings were scheduled, as were appraisals. Staff told us the registered manager was approachable and there was a good level of communication within the service.

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 good.

There were robust recruitment procedures in place to ensure people received their support from staff who had been deemed suitable and safe to work with them. There were sufficient staffing levels to meet the needs of people.

Risks to people's health and wellbeing had been assessed and plans were in place to manage identified risks to ensure their safety.

Staff had received safeguarding training and knew how to keep people safe.

Medication was managed safely.

Is the service effective?

Good

The service was good.

Staff understood the principles of the Mental Capacity Act (MCA) 2005.

Staff received an induction and on-going training to support them to deliver care and fulfil their role.

People were supported to eat and drink to ensure their well-being. General health care needs were met and the service involved other health professionals as necessary.

Is the service caring?

Good

The service was good.

Staff knew people well and had a good understanding of people's care and support needs.

Care plans and risk assessments were detailed and individualised to meet people's needs.

People's independence was promoted and staff encouraged

people to do as much as they were able to.

Is the service responsive?

Good

The service was good.

People's care plans were person centred and contained all relevant information needed to meet people's needs.

There was a clear complaints system in place and complaints were responded to in a timely manner.

Is the service well-led?

Requires Improvement

The service was not always well led.

Improvements were required to some areas of quality assurance.

Staff told us they were valued and supported and morale was high.

There were systems in place to seek the views of people who used the service and others and to use their feedback to make improvements.

Affinity Trust - Domicilliary Care Agency - Southend and Essex

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 30 November, 5 and 8 December 2017 and was announced. We gave the service 48 hours' notice of the inspection visit to ensure the registered manager was available to assist us with the inspection. The inspection was carried out by two inspectors.

Before the inspection, 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 information we held about the service. This included previous inspection reports and notifications we had received. Notifications are certain events that providers are required by law to tell us about. We reviewed the responses to a questionnaire we sent out to 14 people of which three were returned, 70 staff of which 13 were returned and 10 community professionals of which two were returned. In addition, we contacted the local authority to obtain their views on the service.

During our inspection we visited both the service's office and two supported living locations. Not everyone using the service were able to share their experiences of the care provided so we observed the support people received in communal areas.

We spoke with two people, five care staff, one team leader, a support manager and the registered manager. During the inspection we looked at seven people's care records, four staff files, medicine records and other

information relating to the management of the service.

Good

Is the service safe?

Our findings

At our previous inspection in July 2016 we found medicines had not always been managed safely. The systems in place to investigate medication errors or identify concerns and trends to make any necessary improvements were not robust. Although at this inspection improvements had been made, we found there continued to be medication errors. We discussed this with the registered manager who demonstrated to us that they had taken appropriate action. A medication analysis report had been completed which had identified common themes and an action plan had been developed to address these. We did not find any impact on people at this inspection due to medication errors and were assured that the registered manager would be taking appropriate action to ensure the safe management of medicines.

The medication administration records (MAR) we viewed were accurate and complete. Where people were prescribed medicines with specific instructions for administration we saw these instructions were followed, for example, where people had been prescribed time specific medication. Staff responsible for the administration of medicines had completed training and their competency was assessed regularly to ensure they had the skills and knowledge to administer medicines safely. Staff we spoke with told us they had received medicine training and were confident supporting people with their medicines. One member of staff told us, "I feel comfortable giving people their medicines and managers are always very helpful if there are any concerns. The training was good, on line and face to face to ensure I was competent."

All the people who responded to our questionnaire agreed with our question 'I feel safe from abuse and or harm from my care and support workers.' Staff had completed training in recognising the signs of abuse and understood the importance of keeping people safe and protecting them from harm. Staff told us they would report concerns immediately to their manager and were aware they could report externally if needed. Comments included, "If people are not safe I would go to my line manager and, if needs be, the local authority, police or CQC." And, "I would report any abuse. I would write down my concerns and take them to [name of manager]. If they didn't do anything I would go to [registered manager] and to CQC." People using the service were provided with information in pictorial and easy read formats which informed them about how to stay safe and what action to take if they felt they were unsafe or at risk of harm; for example if they are hurt or treated badly by other people. We noted, following a recent safeguarding concern, the registered manager had ensured people were reminded about safeguarding and how to report any concerns.

The service had a positive approach to risk ensuring people's independence could be promoted. Risks to people's safety were managed and reviewed and care plans identified individual risks to people both within the service and when accessing the local community; management plans were in place to mitigate any identified/potential risks.

Staff were knowledgeable about the people they supported and were able to demonstrate an understanding of managing risks whilst allowing people as much independence as possible. To support this approach the service used positive behaviour support (PBS) plans for people with behaviours that challenge. PBS plans focus on preventing behaviours that challenge by recognising the triggers and providing guidance and strategies for staff to follow so as to keep people safe and minimise the risk of

behaviours escalating. For example, one person who was supported by staff with their weekly shopping had a PBS in place. This meant that staff supporting the person were able to minimise the risk of them becoming agitated and displaying behaviours that challenge whilst carrying out this activity in the local community thereby enabling and empowering the person to have as much control and choice as possible.

People were protected from risks associated with infection control. Staff had been trained in infection control procedures and were provided with personal protective equipment (PPE). An infection control policy was in place, which provided staff with information relating to infection control. This included PPE, hand washing and information on infectious diseases. One member of staff told us, "We get provided with enough PPE, we never run out. I always wash my hands before and after all activities and also make sure people wash their hands as well to stop the spread of infection."

There were sufficient staffing levels to meet people's care and support needs safely. People were allocated a core staff team to ensure consistency and continuity of care. The registered manager informed us that there were four staff vacancies and records showed the service was actively recruiting to these posts. The registered manager told us, "We will use agency staff if needed but we try to avoid this and use our bank staff or offer overtime to staff. The majority of staff told us that they felt there were enough members of staff on each shift. One member of staff said, "There is always an issue in the care industry [staffing levels]. They are hiring suitable staff at the moment. In the meantime, we all pull together as a team. We support people with autism so staff need to know people and vice versa, we cannot have just any strangers supporting people."

There was a robust recruitment process in place, including dealing with applications and conducting employment interviews. Relevant checks were carried out before a new member of staff started working at the service. These included obtaining references, ensuring that the applicant provided proof of their identity, right to work and undertaking a criminal record check with the Disclosure and Barring Service (DBS). These checks identified if prospective staff were of good character and were suitable for their role and enabled the registered manager to make safer recruitment decisions. New staff were required to undergo a six month probationary period and the service had disciplinary procedures in place to respond to any poor practice.

Safeguards were in place around people's finances and regular checks were made by senior management to ensure where staff were helping people with their money, the correct procedures had been followed.

Systems were in place to record and monitor incidents and accidents. Staff completed incident forms, which were uploaded onto the registered provider's electronic system and were RAG (red, amber, green) rated depending on the level of risk. These were monitored by the registered manager and the provider to ensure any necessary actions had been completed before being signed off.

Records showed that staff were trained in first aid and fire awareness and how to respond to emergencies. There was a 24hour on call system, which ensured staff could access a manager at any time. There were personal emergency evacuation plans in place for people using the service.

Good

Is the service effective?

Our findings

At our previous inspection, we identified a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as not all staff had received specialist training to equip them with the skills and knowledge to provide effective care to people. Since our last inspection the provider has made improvements and records showed that staff had received specialist training such as Makaton training. Makaton is a language programme designed to provide a means of communication to individuals who cannot communicate effectively by speaking. The service was no longer in breach of Regulation 18 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

Staff told us they received an induction and completed training when they started working at the service. One member of staff said, "I had very good induction training." Staff records confirmed staff had completed an induction programme and the registered provider's mandatory training. The registered manager told us that all staff who were new to care were required to complete the Care Certificate. The Care Certificate is a training course, which enables staff who are new to care to gain the knowledge and skills that will support them within their role and is a nationally recognised programme for the care sector. New staff with previous care experience completed a self-assessment to identify what areas of the Care Certificate they needed to complete or refresh their knowledge on. One member of staff told us, "I have completed the Care Certificate and have had all the training I need. The training is far more in depth than any other training I have had elsewhere." Staff told us they felt supported in their roles and enjoyed their work. Records showed that they received regular supervision and a yearly appraisal of their performance.

The registered provider had an equality and diversity policy in place and was committed to enabling all groups and sections of the community to access and benefit from the support services it provided. The registered provider demonstrated to us that they were committed to promoting and embedding equality and diversity by ensuring people are treated fairly, valuing differences and removing barriers that limit access and opportunities. For example, matching LGBT (Lesbian, Gay, Bisexual and Transgender) people using the service with staff who were able to support them to access links within the LGBT community.

People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, one person had difficulty verbalising. The care plan detailed the person's preferred communication methods. The care plan stated, 'Prefers to use photos or point. I have a communication book with Velcro and I can put two photos on the front to show what I am doing now and what I will be doing next. This has to be used consistently with me and for me to take it everywhere. I also use this to make choices.' Staff we spoke with were aware of this guidance.

People were supported to eat and drink enough. Where relevant, people were involved in the planning of menus and were supported with their shopping. Care plans noted people's food likes, dislikes, and food allergies.

There were processes in place to ensure people received consistent care and support. This included

handover meetings and a communication book.

People were supported to maintain good health. People had health action plans that set out their specific health needs. Records showed that people were supported to access healthcare services as required such as routine screenings, hospital appointments, GPs, dentists and the speech and language team. People also had Hospital passports; these are documents, which include the person's medical and support needs. They are used as a quick reference for sharing information with other healthcare professionals. This ensured continuity of care and reduced people's anxiety for example if they were admitted to hospital.

The Mental Capacity Act (MCA) 2005 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 checked whether the service was working within the principles of the MCA. People's capacity to make decisions had been assessed. This meant their ability to make some decisions, or the decisions that they may need help with and the reasons as to why it was in the person's best interests had been recorded. Staff completed MCA training and were able to demonstrate a good working knowledge of the MCA. They understood the importance of gaining people's consent and helping people to make choices on a day to day basis. One member of staff told us, "We carry out mental capacity assessments but people can make their own decisions mostly. Some people's relatives have Power of Attorney to help make decisions about big things." Another said, "We work in challenging situations and I offer options to avoid confusion. If you give people too many options they can become distressed."

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 registered manager understood the need to liaise with appropriate authorities when people were subject to restrictions that may require authorisation from the Court of Protection. The responsibility of the Court of Protection is to safeguard vulnerable people who lack the mental capacity to make decisions for themselves. These decisions may relate to the person's finances or their health and welfare.

Good

Is the service caring?

Our findings

The service had a strong visible person centred culture. All the people who responded to our questionnaire agreed with the question 'My care and support workers are caring and kind.' Our observations showed that staff provided a caring and supportive environment for people and it was clear people valued their relationships with the staff. One person told us, "The staff are brilliant." We saw that people and staff were relaxed in each other's company. Staff knew people well and interacted with people in a kind and compassionate way.

Where appropriate, people and other relevant people had been involved in making decisions about their care and support. Care plans were person centred and contained detailed information about people's likes, dislikes and preferences in regard to all areas of their care including cultural and religious beliefs. All the staff we spoke with were able to demonstrate a good knowledge of how people wished to be supported.

The registered provider had systems in place to ensure effective communication for people using its services. Information was available in accessible formats such as large print, pictorial and Makaton. All the people who responded to our questionnaire agreed that 'The information I receive from the service is clear and easy to understand.' This meant that people received information in a way that helped them to understand it. Care plans also contained communication profiles, which clearly stated people's individual communication needs. There were also communication dictionaries to aid communication with people who were unable to verbalise. These recorded the actions displayed by people, what staff thought these actions meant and what the person would like staff to do. For example, for one person it had been recorded that if they were running up and down the stairs laughing it meant they may have broken something or done some damage to their room. This was a cue for staff to go upstairs with the person to see the damage and help them to clear it up.

The service was committed to providing people with privacy and dignity. Care plans recorded when people may want some privacy and this was to be respected. We saw staff knock on people's doors and asking permission to enter. Staff were also able to provide us with examples of how they ensured people's privacy and dignity was respected. For example when providing personal care and making sure people were dressed appropriately when accessing the local community.

People were supported to be as independent as possible. All the people who responded to our questionnaire agreed 'The support and care I receive helps me to be as independent as I can be.' Staff encouraged people to do as much as they could for themselves and care records recorded what people could do for themselves and where they needed support. This ensured that staff provided care in a way that helped to maintain people's independence. One member of staff told us "I support someone who self-administers [medication] and I help them to continue to do this and remain independent."

People were supported to maintain links with their families and friends. For example, one person had been supported to visit their family member who lived in a care home. The support manager explained this had been a long process and that the person was now able to visit and stay for a short period of time. They went

on to say, "This is a significant step for [name of person]." Another person was being supported to re-establish a relationship with their family. A member of staff told us, "We are supporting the whole family to redevelop their trust and maintain a good relationship."

The service had information about local advocacy services and one person was currently being supported by the service to access an advocate. An advocate supports a person to have an independent voice and enables them to express their views when they are unable to do so for themselves.

Good

Is the service responsive?

Our findings

Appropriate arrangements were in place to assess the needs of people prior to them using the service. Assessments were undertaken to identify people's health, personal care and social support needs. Where appropriate people using the service and the people that mattered to them were involved in the planning and reviewing of their care needs. Care plans were reviewed regularly or as and when people's needs changed.

People received consistent personalised care and support. Staff we spoke with were knowledgeable about the people they supported and were aware of their likes and dislikes, interests and health and support needs. The care plans we viewed were person centred and included information on people's life histories and what was important to people and how they wished to be cared for. For example, when we made a home visit staff ushered us into the staff office informing us that the person would become anxious and distressed if we remained talking in the hallway; this was reflected in their care plan. In another person's care plan it had been recorded the person was able to communicate effectively but may need encouragement to open up to staff at times as they were often more able to make sense of their thoughts if they wrote them down and staff should encourage them to write in a letter what was troubling them. This meant there was clear information and guidance available on how staff were to support people in a person centred way.

People were encouraged and supported to pursue their hobbies and interests. One person told us, "With staff help I have a much fuller day of activities than before I lived here." We saw many examples during our inspection of how people were supported to access the community and take part in activities, social events and to pursue their hobbies and interests. For example, on the second day of our inspection one person was supported to travel to London to see Cinderella on Ice and another person supported to access a local cycle club, which they regularly attended and thoroughly enjoyed. One staff member told us how they supported a person who was diagnosed with autism and schizophrenia. They told us, "People were scared of [person] because they shouted a lot and presented behaviours that challenged but I've worked with [person] and we go out to London; [person] loves it and we take photos. I have been able to show staff how to work with [person]." Another said, "It's the little things which make a difference. I take time each day with people and provide them with normality. I engage with them and support them to get engaged with the local community. If you don't support this people are hidden away and isolated. Doors open up by introducing people to events in the community."

The service had an effective complaints system. There was a clear complaints policy and procedure in place, which was also available in easy read pictorial format, which explained when and how complaints would be investigated. Records confirmed complaints had been dealt with appropriately in line with the provider's policy and procedure.

Although no one living at the service was receiving end of life care, care records showed that not all people using the service had end of life care plans in place. Where end of life care plans were in place they did not detail how people were to be supported at the end of their life to have a comfortable, dignified and pain-free

death. We discussed this with the registered manager who informed us they would take immediate steps to ensure people's wishes were clearly documented.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager who had been registered with the Commission since March 2017. Throughout our inspection the registered manager demonstrated their commitment and passion to ensuring people received good quality care. They were supported by three support managers with the day to day management of the service.

There were systems in place to monitor the quality and safety of the service, which included an annual yearly comprehensive quality audit for each person using the service. These were completed by the registered manager or other senior managers. Where actions had been identified action plans were developed and re-audited within three months to check actions had been completed. However, although staff could tell us how they supported people, on reviewing care records we found record keeping had not always been consistently maintained; for example, to demonstrate how the service was supporting people to achieve their goals and aspirations. We also found gaps in two people's daily communication records and we could not be assured as to whether people had received support in line with their commissioned hours. Although we identified improvements were required to record keeping there had been no impact on people using the service. We discussed our findings with the registered manager who acknowledged this was an area requiring improvement and informed us they would address this at staff workshops, which were currently in the process of being planned to improve the quality of the service.

We recommend the registered provider review their systems in place to monitor and maintain accurate and complete records in relation to the care and treatment people receive.

Since our last inspection there had been management changes at the service. Staff we spoke with said morale had improved and they felt supported and valued and enjoyed working at the service. The registered manager sent thank you cards in recognition of staff who had gone 'the extra mile'. For example, we saw a thank you card to a member of staff who had supported a person to move into the service in a way, which had reduced their anxieties and challenging behaviour. A member of staff told us, "This is the first time I have worked in a company like this. I trust them and they trust me. [Management] are very supportive, I have never had this in other jobs." Another said, "I feel the structure of the management and communication is much better now. I have regular supervisions and management come out and visit. This also means people get to meet higher management." The registered manager told us they operated an 'open door' and this was confirmed by staff who told us they felt confident to speak openly and honestly with the registered manager.

The service embraced the principles that underpin the 'Registering the Right Support' and other best practice guidance; these include choice, promotion of independence and inclusion. The registered manager informed us that the provider was signed up to the Driving Quality Code (the Code). The Code was developed following the Winterbourne review that identified abuse of people with learning disabilities at Winterbourne View. The government and many other organisations that support people with learning disabilities are making sure that this never happens again and to drive up quality in services for people with learning disabilities that goes beyond minimum standards; thereby empowering people with learning

disabilities and autism to live as ordinary a life as any citizen.

Regular staff meetings were held and topics such as updates on people living at the service, training, and the day to day running of the service were discussed. Staff were also involved in workshops to help improve the quality of the service people received. For example, one member of staff whose family member had a learning disability was part of a working group to review and improve care documentation. The registered manager told us it was important to recognise staff's strengths and skills and utilise these to improve the service. This showed us that staff had the opportunity to be involved in how the service was run.

The registered manager actively sought the views of people who used the service and others. This was done in a number of ways such as daily interactions with people, resident meetings and surveys. Feedback was taken into account to improve the quality of the service.

The registered manager told us they received good support from the registered provider. They attended meetings, which provided them with an opportunity to share good practice, discuss challenges and keep up to date with changes in the care sector.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.