Shaw Community Living (DCA) Limited

Shaw Community Services Limited (DCA) - Herefordshire 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: Shaw Community Services Limited (DCA) - Herefordshire Branch is registered to provide personal care and supported living services. This service provides care [and support] to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is [bought] [or] [rented], and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care [and support] service.

The provider registered this service with us to provide personal care and support for people with a range of varying needs including dementia, who live in their own homes. At the time of our inspection 32 people received support in the extra care scheme and 7 people with personal care in the local community.

People's experience of using this service: The people using the service felt safe and had confidence in the provider to act on any concerns. People told us, "I feel safe I have no worries. I have people around me that actually care about me and I get on well with all the staff", and "The staff are brilliant, very competent and know exactly what they are doing", and "I have totally trust in the staff when they provide my care, the [staff] know what I need and do a great job, no complaints", and "The service really is tailored to my [relative] needs. They provide a brilliant service that is flexible to meet our needs".

Sufficient numbers of staff had been recruited. Safe recruitment practices had been followed, and all records required were in place.

Everyone we spoke with told us that they mainly enjoyed the food prepared by staff. People's nutritional needs were known and met by staff. People told us they always received their choice of food and enjoyed the meals prepared for them.

Consent to care and treatment was sought in line with the principles of the Mental Capacity Act 2005. People told us staff always asked for their consent before providing support.

People told us staff were kind and caring and that their dignity was protected by staff. This was also reflected within the responses to surveys and within the compliment cards and letters we looked at. People told us the staff knew them and supported well, including their needs and preferences.

Care plans were clearly recorded. They detailed how people wished and needed to be cared for. They were regularly reviewed and updated as required with changes in care and support clearly signposted. We saw that relatives were involved in supporting staff to understand how people wished to be cared for. The care files had been reviewed regularly and people were involved in these reviews.

Systems were in place to gather feedback from people regarding the service and action was taken to

improve the service, based on the feedback. The registered manager and senior staff also completed regular audits and addressed any areas identified as requiring improvement to improve the service provided to people.

Rating at last inspection: Good published (28 August 2016)

Why we inspected:
This was a planned inspection that was scheduled based on the previous rating. We inspected to check whether the service had sustained its Good rating.

Follow up:
We will follow up on this inspection through ongoing monitoring of the service, through conversations and checking relevant notifications.

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.

Shaw Community Services Limited (DCA) - Herefordshire Branch

Detailed findings

Background to this 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: The inspection was undertaken by one adult social care inspector.

Service and service type: Shaw Community Services Limited (DCA) - Herefordshire Branch is a domiciliary care agency providing personal care support to people in their own homes.

The service had a manager 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 24 hours' notice of the inspection visit because it is small and we needed to be sure that someone would be available.

What we did:
Before the inspection
• We reviewed notifications we received from the service in line with their legal obligations.
• We looked at information the provider had sent us about the service in the Provider Information Return (PIR).

During the inspection

• We looked at the care records belonging to five people using the service. Five staff recruitment records, medicine administration charts and other records relevant to the quality monitoring of the service.
• We reviewed records of safeguarding investigations, accidents, incidents and complaints.
• We discussed quality assurance processes and checked recruitment, supervision and training information.
• We spoke with six people who used the service and observed interactions between them and their staff.
• We spoke with three relatives of people using the service.
• We spoke with five care staff members, the care supervisor, care coordinator, the operations manager and the registered manager.

Good

Is the service safe?

Our findings

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

People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse
• Staff were aware to report safeguarding concerns.
• Staff had received training on how to protect people from abuse and a policy was in place to guide them. Staff were knowledgeable about safeguarding processes and how to raise any concerns they had.
• The registered manager and senior staff maintained a record of safeguarding concerns and referrals had been made to the local authority when required.
• A whistleblowing policy was in place and staff were aware of the procedures to follow with regards to this.

Assessing risk, safety monitoring and management
• People told us they felt safe because they received safe care and could talk to staff if they needed to. Relatives responses from a recent survey included, "I feel confident that [person] is safe and well cared for" and "I am very satisfied that my [relative] is getting the best care".
• Risks to people were managed in a way that respected individual diverse needs. Measures had been taken to reduce identified risks to people.
• Equipment and utilities were checked regularly to ensure they remained safe for use.
• Emergency procedures for keeping people safe were in place and they were regularly reviewed and updated as required. These included personal emergency evacuation plans (PEEPs) at the serice and an overall emergency procedure plan.

Staffing and recruitment
• People and their relatives told us there were sufficient numbers of staff to meet people's needs. Their comments included, "I know who is coming [staff] they are the same ones all the time which is marvellous", "The care staff are always available, they are wonderful" and "I constantly have the same staff, I can't fault them".
•We looked at five staff recruitment records and all were in order with all relevant checks completed.
• The service did not use agency staff, the care coordinator told us that if staff were absent at short notice that the senior staff provided the relevant calls for people's care.
• Changes to the staffing structure had been made since the last inspection, including a new registered manager and the old manager becoming the operations manager.
• Staff were safely recruited by the service. Checks such as criminal records checks, known as Disclosure and Barring Service (DBS) records, were carried out. This helped to ensure that only people who were suitable to work with vulnerable adults were employed by the home.

Using medicines safely
• There were procedures in place to support the safe administration of medicines. There was a medication policy which covered the process staff needed to follow. Staff also had access to best practice guidance

regarding medicines.
• Medicines were stored safely in people's homes.
• Staff had completed training and had their competence assessed every three months to ensure they were safe to manage people's medicines.
• People told us they got their medicines when they needed them and a relative told us, "Staff know what [medicines] my [relative] needs and when they need them. There has never been any issues".
• Records of medicines administered were maintained and we saw that all had been completed accurately. All contained information regarding any allergies people had to medicines and consent records were available in line with best practice.

Preventing and controlling infection
•Systems were in place to safely manage and control the prevention of infection. Staff had received training and Personal Protective Equipment (PPE) was stored in people's homes and at the service. Staff were seen to use PPE when supporting people with specific tasks to prevent the spread of infection.

Learning lessons when things go wrong.
• A system was in place to monitor any incidents or accidents which occurred. This allowed for any patterns or trends to be identified so that action could be taken to prevent recurrence.
• Appropriate actions were taken following incidents, such as seeking medical advice, updating risk assessments and care plans and providing any necessary equipment.
• The registered manager and senior staff acted to ensure lessons were learnt from any incidents. For instance, medicine audit checks showed that there were omissions in signatures by staff. Actions recorded that all staff must be assessed every three months for medication competencies. This was taking place, we saw competency records and staff told us they were monitored and assessed administering medication in people's homes.
• Monitoring records looked at were completed, records included monitoring food fluid records, infection control use of Personal Protective Equipment (PPE), notifications, gender preference, health and safety checks. All areas had outcomes and actions taken where required.

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.

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

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 with appropriate legal authority. In care homes, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• The registered manager and senior staff were knowledgeable regarding the MCA and what they needed to do if they felt they were being restricted and required a referral to the Court of Protection.
• Records showed that people had consented to their plan of care. They had also signed to agree to CQC reviewing their care plans and to have access to their contact details.
• When an authorised Power of Attorney was in place for people, the registered manager held copies of this to help ensure relevant people were involved in decision making when needed.
• Staff had received training and had a good understanding of the MCA. Staff told us they always asked for people's consent before providing care and people confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Staff had access to best practice guidance, The National Institute for Health and Care Excellence medicine guidance. Guidance from the local authority was also available, such as safeguarding procedures and thresholds.
• Care and support was planned, delivered and monitored in line with current evidence-based guidance, legislation, standards and best practice.
• Detailed care plans were developed from initial assessments and included input from other health and social care professionals when required.
• When people had specific medical conditions, information regarding these conditions was held within the care files. This information also provided best practice guidance on how best to manage the condition to ensure people received safe and effective care.

Staff support: induction, skills, training and experience
• Staff completed regular online training in areas relevant to their roles, to ensure they could support people effectively. Staff were required to attend onsite training for practical training including moving and safe handling people, medication and health and safety.
• People and their relatives told us they felt staff were highly trained and able to meet their needs safely.
• New staff had completed a comprehensive induction which met the governments recommended induction standards. Staff competence was assessed during the induction process.
• Staff told us they received sufficient training and felt it helped to support them in their roles as it ensured they were kept up to date with good practice. Staff were supported by the providers to register for qualifications in care.
• Staff felt well supported and received regular supervisions and an annual appraisal to discuss their roles and any development required.

Supporting people to eat and drink enough to maintain a balanced diet
• People's nutritional and hydration needs and how they were to be met were recorded in their care plans. People received the support they needed to eat and drink and maintain a healthy and balanced diet.
• Records showed that when people required their intake to be monitored, this was recorded to ensure that people ate or drank sufficient amounts. Systems were in place to ensure these records were completed accurately and reviewed regularly.
• People told us they had enough to eat and drink and that staff always asked what they wanted before they prepared the meals. Comments from people and their relatives included, "Food is good, I enjoy it, it's what I want", "The staff provide what I ask them too, they are all good cooks".
• We saw that people were monitored if required for food and fluid intakes and early intervention taken if people started to lose weight.

Supporting people to live healthier lives, access healthcare services and support
• The service worked with other health and social care professionals to help ensure people's healthcare needs were met.
• When other health and social care professionals were involved in people's care, this was recorded within their care files so all staff knew how the person should be best supported.
• Care files contained a completed transfer form to enable people's details to be shared with other professionals, such as hospital staff.
• Staff told us they would report any concerns regarding people's health to the registered manager, so they could liaise with family or the person's GP if appropriate.
• The registered manager told us that when necessary, staff supported people to attend medical appointments.

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

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
• People told us staff were kind and caring and treated them with respect. One person told us, "Staff are very kind, nice people" and another person said, "All the staff try their best for you, they are really kind", and "Staff are very good, very kind they are the best staff we have used".
• Relatives agreed and their comments included, "The staff are really lovely and the care and treatment of my [relative] is really good", "Staff are approachable and knowledgeable and communicate with us [family] when we visit [relative] or by telephone if required", "Can't fault them [staff] they are so kind" and "They treat my [relative] like a friend, its lovely to hear the conversations".
• Comments in recent relative surveys included, "My [relative] is treated with care, and respect" "The staff treat [relative] with dignity, respect and also good humour", "The care provided is really good and my [relative] health depends on their input and support immensely" and "I could not fault any of the care staff". Compliments and thank you cards and emails received by the service were viewed.
• Staff knew the people they were supporting well, including their needs and preferences. This knowledge was used to develop individual plans of care that reflected the support people wanted and needed.
• We observed positive, familiar interactions between staff and people at the service when they were in communal areas.
• Staff understood how to communicate with people most effectively for the individual. They knew when people required additional support due to hearing or visual impairment. When people were not able to communicate verbally, staff told us about specific body language signs they looked for to help understand the person's needs.

Supporting people to express their views and be involved in making decisions about their care
• People told us they had choice and could make decisions about their support. People told us they got up and went to bed whenever they chose and ate their meals when they wanted to.
• Not all people recalled being asked their views of the service, however records showed that they had completed surveys as a means of gathering their views.
• Regular bi- monthly tenant meetings were also held at the service for people to discuss their care.
• People and their family members told us they felt confident to be able to raise any concerns they had with the management and that they would be dealt with.
• A service user guide was available to people. This provided information regarding what the service provided and what people could expect, to help them make decisions regarding their care.
• Records showed that people were consulted regarding their care and supported to make decisions in relation to this. Advocacy services were available to people and we were told by the registered manager that no one was currently using an advocate.

Respecting and promoting people's privacy, dignity and independence
• People told us they felt staff protected their dignity and privacy. One person told us staff always knocked before they entered their flat and would shout if it was ok to enter. Another person said they felt their privacy was respected as, "Staff are brilliant they make sure that when they transfer me numerous times a day I am safe, happy, comfortable and covered appropriately".
• Staff clearly described how they protected people's dignity and privacy, including closing doors and curtains when providing personal support and helping people to remain covered with towels.
• Records regarding people's care and treatment were stored securely.
• People told us that staff encouraged them to be as independent as they could be and records reflected this.
•The care coordinator told us about specific examples of how staff had gone above and beyond what was expected of them to ensure people were happy and that their needs were met. Including walking to people in the bad snow where cars could not gain access to ensure they received their care.
• Staff signed confidentiality agreements when they were recruited, to help ensure information regarding people using the service was treated appropriately.

Good

Is the service responsive?

Our findings

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

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs preferences, interests and give them choice and control
• People's individual needs had been assessed and care plans developed to meet those needs.
• Care plans were detailed regarding the support people required and had been reviewed regularly. The care plans were in the homes of the people using the service for staff and access for information for other relevant health and social care professionals. There were also copies of care plans appropriately stored in the office at the service.
• Information was recorded regarding people's preferences in relation to their care and treatment, daily routines and how they liked to spend their time.
• Rotas for continuity and reliability were in place and the service met this by 100% providing the same carers and ensuring staff were punctual. People told us that they had the same staff and they were always on time. One person told us "Excellent staff, I seriously rely on their visits to my [relative], they encourage [relative] so much. They are always on time as my [relative] has a lot of visits daily and by two staff each visit. They work with [relative] responding to how he is on the day and each visit, really. I cannot praise them enough".
• Relatives told us they were aware of the plans of care in place and were always informed of any changes. One relative told us "Communication is really good from staff they inform our family immediately if there are any changes in [relative] health. It's so important as we cannot be there.
• Staff knew the people they supported well, including their dietary needs and preferences, activities they preferred, how best to approach people and how to support people if they became agitated or upset.
• The service was meeting the Accessible Information Standards as they assessed, recorded and shared information regarding people's communication needs. The service identified people's information and communication needs by assessing them. Staff understood the Accessible Information Standard. People's communication needs were identified, recorded and highlighted in care plans. These needs were shared appropriately with others. We saw evidence that the identified information and communication needs were met for individuals, for example the care supervisor initiated that the provider write all correspondence in a certain font size to one person who was unable to read small print. Another example written in a care plan was for staff to ensure they had eye contact with the person when speaking to make sure the person understood them.
• Staff completed daily logs to record the care provided, so all staff had up to date information regarding people's care. Daily logs reflected that planned care was delivered and also what quality time was provided for example, reading mail at request, sitting talking about everyday things that the person shows interest in.
• People told us that the service was really flexible and they implemented changes to their care plan to meet their requirements. For example, increasing the time for an individual at very short notice when a relative requested it. Also, increasing and decreasing care and support when requested due to people's health changes. A relative told us "The service is excellent, they really do support me and my [relative] so that our mental wellbeing does not deteriorate. They provide respite care for my [relative] at very short notice and

always provide staff that know exactly what they are doing".
• Although the service was not responsible for providing activities a range of activities were available to people, both within their home and the local community if requested. Staff encouraged people to continue hobbies and interests they enjoyed.

Improving care quality in response to complaints or concerns
• A complaints policy was available and this was on display within the extra care service and in all of the people's homes we visited.
• All the people told us they knew how to make a complaint should they need to and relatives agreed. All told us they had no reason to complain at the present time.
• The registered manager maintained a log of any complaints received and records showed they were investigated and responded to appropriately. There had been one complaint raised since the last inspection that was responded to effectively with actions and monitoring records implemented to ensure the person and staff were working together for the best outcome. The registered manager had completed a detailed investigation and provided a robust response to the complainant.
• The registered manager told us that complaints would be received positively and used as an opportunity to improve the service.

End of life care and support
• The registered manager and senior staff told us they worked with the community nurses and GP's during these times, to ensure people received appropriate care and support.
• The staff were aware of people's choices and told us that people and their families would be hesitant to discuss end of life and plans initially.
• The care plans contained relevant information concerning the wishes of people, their religious beliefs and in some files the funeral directors chosen.

Good

Is the service well-led?

Our findings

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

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

Leadership and management Provider plans and promotes person-centred, high-quality care and support
• People provided positive feedback regarding the quality of the service they received. People told us staff usually arrived on time and stayed until their needs had been met in the way they wanted.
• Staff told us they felt listened to and that the registered manager was approachable. Comments included, "There is someone available to contact 24 hours a day should we need them" and "Yes I feel it is managed to the highest standard, nothing for staff or people using the services is too much trouble, all our needs are meet".
• Staff told us they worked well together as a team to deliver high standards of care.
• The registered manager and staff had a good understanding of their roles and responsibilities within the service. Staff files included job descriptions to support this.
• People told us they felt the service was managed well they knew who the new manager was and would tell them or one of the senior staff if they had any concerns.
• Relatives told us the service was managed well. Comments included, "[Registered manager] is very good at her job, open to change and good practice", and "[Registered manager] is genuinely interested in continued service development and has a good team supporting her".
• Staff felt well supported in their roles and told us, "Our seniors and management are very supportive of us" and "If I have a problem of any nature whether it be personal or work related I would not hesitate in calling in to the office at any time to discuss it with them, in fact we are encouraged to do so".
• The registered manager was aware of incidents that CQC should be made aware of and had submitted statutory notifications appropriately.
• The registered provider had displayed their rating within the office and on their website as required.

Engaging and involving people using the service, the public and staff.
• Systems were in place to gather feedback regarding the service. These included regular surveys to gather views from people receiving support. Regular staff meetings were also held and staff were encouraged to share their views during these meetings.
• Regular reviews were undertaken with people using the service to ensure their care plans remained effective in meeting their needs.
• People could contact the service at any time as an on-call system was in place.

Continuous learning and improving care
• The registered provider had systems in place to assess and monitor the quality and safety of the service. These included audits of staff files, care plans, medicine records and daily records, as well as direct observation of staff in practice.

• These checks were diarised to help ensure they were completed regularly.
• When actions were identified through the audit system, they had been addressed to improve the service.
• The registered manager met regularly with other registered managers from Shaw community services to share knowledge and help ensure care was provided in line with best practice guidance.

Working in partnership with others
• The registered manager worked closely with other agencies to ensure good outcomes for people. For example, they described how they liaised with social services to arrange an occupational health referral for one person whose mobility had deteriorated. They also worked closely with people's GP's in relation to medicines management.