Affinity Trust

Affinity Trust - Domicilliary Care Agency - Cambridgeshire

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

Affinity Trust – Domicilliary Care Agency – Cambridgeshire is registered to provide personal care to people who live in their own homes in the surrounding Cambridgeshire towns and villages. At the time of this inspection care was provided to 46 people who live with a learning disability and who may have mental and physical health needs.

This comprehensive inspection took place on 10 May 2016 and was announced.

A registered manager was in post at the time of the inspection and had been registered since 2015. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the agency. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were kept safe and staff were knowledgeable about reporting any incident of harm. People were looked after by enough staff to support them with their individual needs. Pre-employment checks were completed on staff before they were assessed to be suitable to look after people who used the service. People were supported to take their medicines as prescribed.

People were supported to eat and drink sufficient amounts of food and drink. They were also supported to access health care services and their individual health needs were met.

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA 2005] and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. The provider was aware of what they were required to do should any person lack mental capacity. People's mental capacity was assessed and care was provided in their best interest. Staff were trained and knowledgeable about the application of the MCA. Arrangements were in place for external agencies to assess people and make DoLS applications to the Court of Protection [CoP], if these were required. The outcome of these assessments was pending.

People were looked after by staff who were trained and supported to do their job.

People were treated by kind staff who they liked. They and their relatives were given opportunities to be involved in the review of people's individual care plans.

People were supported to increase their integration into the community; they were helped to or take part in recreational and work-related activities that were important to them. Care was provided based on people's individual needs. There was a process in place so that people's concerns and complaints were listened to and these were acted upon.

The registered manager was supported by a team of management staff and care staff. Staff were supported

and managed to look after people in a safe way. Staff, people and their relatives were able to make suggestions and actions were taken as a result. Quality monitoring procedures were in place and action was taken where improvements were identified.

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.

Staff were aware of their roles and responsibilities in reducing people's risks of harm.

People's needs were met by enough staff who had been deemed suitable.

People were given their medicines as prescribed by staff who were trained and assessed to be competent.

Is the service effective?

Good

The service was effective.

People were looked after by staff who were trained and supported to do their job.

Mental capacity assessments were in place to show that people's rights were protected from unlawful decision making processes.

People's health, nutritional and hydration needs were met.

Is the service caring?

Good

The service was caring.

People were looked after in a caring way and their rights to independence privacy and dignity were valued.

People were supported to maintain contact with their relatives.

People were involved in making decisions about their care.

Is the service responsive?

Good

The service was responsive.

People's individual needs were met.

People took part in a range of social and recreational activities

that were important to them.

There was a procedure in place which enabled people to raise their concerns and complaints.

Is the service well-led?

Good

The service was well-led.

Procedures were in place to monitor, review and improve the safety and quality of people's care and support.

People and staff were provided with opportunities to make suggestions in relation to the management of the service.

The provider operated an open and transparent service.

Affinity Trust - Domicilliary Care Agency - Cambridgeshire

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 10 May 2016 and was announced.

The provider was given 24 hours' notice because the location provides a supported living service; we needed to be sure that someone would be in.

Before the inspection we looked at all of the information that we had about the service. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. Also 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.

Prior to the inspection we made contact with a local authority monitoring officer. This was to help with the planning of the inspection and to gain their views about how people were being looked after.

During the inspection we visited the agency's office and two of the homes where people lived. We spoke with two people and three people's relatives. We also spoke with the registered manager; one operations manager; two support managers; one team leader; three members of care staff and one member of care staff supplied by an external agency.

Due to their complex communication needs the majority of people were unable to verbally tell us their views about their experience of being looked after. Therefore, we observed people's care to assist us in our understanding of the quality of care people received.

We looked at four people's care records, medicines administration records and records in relation to the management of staff and management of the service.

Good

Is the service safe?

Our findings

We saw that people engaged freely with members of staff and this told us that people they felt safe with staff who were looking after them. Relatives told us that their family members were safe and gave their reasons for views. One relative told us that their family member's garden gate was kept secure; this was to reduce the risk of them going out alone onto a road, which they would be unsafe to do so. Another relative said, "I trust the staff. I believe that there would be changes in [family member's] behaviours. I would know if something was not right." They told us that their family member was happy and settled due to how well staff treated them.

Relatives and staff members told us that there were enough staff to look after people. One support manager said, "The staffing ratio is according to whatever the person support needs are." We saw people were being looked after by enough staff. This included support on a one-to-one or two-to-one basis. The staffing numbers and ratios of staff were determined based on people's individual needs and assessed risks to keep them safe at all times. This included, for instance, an increase in the number of staff to meet people's increased mobility needs and to enable them to safely take part in community-based activities.

Measures were in place to cover staff vacancies and absences, which included the use of bank staff and staff supplied from an external agency. One such member of agency staff told us that they had worked most weeks, looking after the same people since December 2015. One support manager said, "For consistency, agency staff have worked with people for about six months." One relative told us that they felt their family member was safe and attributed this to the way they were looked after. They said, "What I like about it is there is such a good, stable team of staff. [Family member] seems to see the same ones [staff members] as [family member] doesn't like change."

Staff were trained and knowledgeable in recognising and reporting any incidents of harm to people. They were able to describe what types of harm people may experience and the action they would take in reporting harmful incidents to the local authority. Members of staff were also aware of recognising signs that people may show if they were being harmed. One support manager said, "The obvious signs would be withdrawal; bruising; a change in the person's usual presentation or behaviour." The provider had submitted notifications to us: the information told us that appropriate actions had been taken to protect people from the risk of recurring harm. This included, for example, reviewing the suitability of members of staff in line with the provider's disciplinary procedure.

People's risks were assessed and these included risks associated with behaviours that challenge, using transport and risk of fire. Measures were taken to reduce the likelihood of people experiencing harm. These included, for example, ensuring that there were strategies in place to enable a person to become settled; there were enough staff available to support people to use transport; people had personal emergency evacuation plans in place for staff to follow in the event of a fire.

Staff members were aware of keeping people safe from the risk of harm. One support manager said, "Risk assessments are to identify [people's] risks, such as making a cup of tea. We may need to help the person fill

the kettle." They also added, "You have to take risks to do things in life. You can't eliminate every situation but we can do our best to provide people with information to help them make the decision about the risk. Or to make the decision for them [as part of a best interest decision]. It's individual to each person you support."

In their PIR the provider wrote, "All staff have enhanced DBS [Disclosure and Barring Service] checks, right to work checks, full employment history and two references before commencing in post." Members of staff told us that they had attended an interview and had all the required checks in place, which included a DBS and written references. One member of care staff said, "I couldn't start [work] before they [checks] had all come through." One support manager added that the recruitment process enabled the provider to assess prospective staff members' values and understanding of the principles of good care. They said, "We are looking for the right ethos for the service. Such as promoting people's independence and not de-skilling people who we support." The operations manager also told us that the recruitment process enabled them to assess the prospective members of care staff's understanding of valuing people's rights to dignity and independence.

The provider told us in their PIR that there had been a number of errors in the management of people's medicines between 2014 and up to August 2015. We received notifications in relation to the issues and were satisfied that people had experienced no harm because of the errors. We were also satisfied that the provider had taken effective action to reduce the numbers of errors associated with the management of people's medicines. This included, for example, the retraining and re-assessment of staff's competency in supporting people with their prescribed medicines.

People's relatives told us that they were satisfied with how their family member was supported to take their medicines as prescribed. One relative said, "[Name of family member] does get [family member] medication prescribed by the doctor. Sometimes it is when they get anxious."

Medicines administration records showed that people had taken their medicines as prescribed. Members of staff, who were responsible in managing people's medicines, were trained and assessed to be competent to do so. One support manager said, "The support workers [care staff] are trained to do medicines. I sign people [staff] off after completing their medication competency assessments. Any new staff has to attend training in medicines and their competency assessments have to be signed off before they can give anyone their medicines."

Staff members had access to clear guidance in how to support people to take their medicines in the way that they preferred. The use of covert medicines [medicines disguised in food or drink] was carried out based on the provider's best interest decision making procedure. One support manager gave an example of when this infrequent practice was used: they told us that the use of covert medicine was to enable a person to have essential dental treatment. Health care professionals, the person's relative and key members of staff had been collectively involved in the best interest decision making procedure. They said, "I had to get special permission from the clinical psychologist, community nurses; the care manager [from the person's funding authority] and family [relatives]."

Good

Is the service effective?

Our findings

The provider told us in their PIR that staff attended training and were supervised; they wrote and said, "All staff undergo a probation period, and are now completing the care certificate within the first 12 weeks of employment. Staff inductions take place and the manager meets with new staff for supervision every month during the probation period. All staff attend a series of mandatory training courses which equips them with relevant information and skills to work safely and effectively."

Members of staff said that they had attended training, which included induction and refresher training. One member of care staff described their induction training and said, "I had training in [looking after people with] autism and epilepsy. My first three shifts I 'shadowed' a support worker [member of care staff]. Actually following them and the routine. I have my safeguarding training coming up in June [2016]." Another member of care staff said, "The training is usually pretty good." One support manager said, "The induction training is five days if not more. There is induction to the company; shadow shifts with core [permanent] staff members and then we meet for a one-to-one meeting. [The meeting] is to discuss how they are getting on; how they are feeling; are they ready to work alone with people. Do they feel confident and competent and do we feel they are confident and competent?" Another support manager said, "I've always been able to ask for additional training." They told us that they had requested additional training, to improve how they were able to meet one of the people's mental health needs, and their training request had been actioned. Additional staff were supplied from an external agency and the operations manager said, "Agency staff are used and their training is checked by us [to assess their suitability]."

Staff said that they felt supported and were supervised to do their job. Supervision enabled staff members to discuss their health and wellbeing, work-related matters and training and development needs. One support manager added, "Supervision is an opportunity to give staff clear actions and goals and discuss objectives they have set for themselves. This would also include the organisation's [provider's] business plan. Staff attend a 12-month annual performance review." The registered manager told us that, since they came into post in 2014, one of their main aims was to improve the support and supervision of staff. They said, "The focus was on staff teams; supporting staff. Staff morale has improved."

Management and support of staff during times of change is essential to enable change to effectively take place. The provider had recently taken over the management of people's care in one of their homes; changes were being made to improve the quality of people's care. One support manager told us that staff were encouraged to adapt to new ways of working and were supported in doing so. One member of care staff said, "The staff are 'running' [working] how they should." They gave an example of the changes being made to improve the quality of people's lives. They showed that they welcomed the changes and felt supported and guided in contributing to these changes. One support manager advised us that team meetings were used to support and educate staff in providing good, quality care. The next team meeting was due to take place on 13 May 2016. One member of care staff described the team meetings as "informative and useful."

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 application procedure for this in registered services is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The provider was aware of their roles and responsibilities in relation to the application of the MCA. In their PIR they wrote, "Each person supported is assessed for capacity to receive/accept support. If it is believed that a person lacks capacity, any potential restrictions are identified using a screening tool and best interest meetings are held and documented. For any identified restrictions we notify the person's care manager for them to make an application to the court of protection for the restrictions to be considered." The information in the PIR demonstrated that the provider was also aware of monitoring any authorised DoLS applications; they wrote, "We review the restrictions in place under MCA/DOLS to ensure these are the least restrictive."

Staff were trained and knowledgeable regarding the MCA. One support manager said, "Always assume somebody has mental capacity in relation to supporting a person. You should try and do anything in your means to communicate with the person to try and establish if they do or don't have mental capacity." People's mental capacity was assessed and records demonstrated that communication methods were used to enable the person to take part in the mental capacity assessment process. One support manager and the operations manager advised us that action had been and was being taken for people to be referred to the appropriate agencies: this was where restrictions were imposed based on safety reasons; for example, restriction of people's access to their kitchen area due to the outcome of a risk assessment.

People's dietary preferences were assessed with their food likes and dislikes recorded, based on what people had told staff. Relatives told us that their family member had enough to eat and drink and were able to choose what they wanted. Two members of care staff described how they supported people to choose what they wanted to eat when they shopped for food. People's nutritional and hydrations risks were identified and measures were taken to minimise the risk. This included monitoring and recording people's food and drink intake.

We saw a member of care staff prompt a person to drink and we also saw some of the people eating finger food as an afternoon snack. One support manager described how one of the people needed help to eat their food and said, "One person sometimes takes the spoon [to eat from]. Sometimes [person] just won't. So we help them then." They also told us that special diets were catered for, which included cultural diets. The operations manager advised us that at least one person required their food to be cut up in manageable bite-size pieces for them to independently eat their food.

People were supported with their individual health needs and to gain access to a range of health care professionals. The provider wrote in their PIR, "We have been working very closely with other professionals including Psychiatry, Psychology, community nurses and mental health specialists."

One person told us that they had a dental check; they showed us that they were pleased that they had a clear dental check and did not need any follow-up treatment. Relatives told us that their family members

were kept healthy. One relative told us that they were pleased with how this was managed and said, "If the staff think there is something not right, they get the GP around. When [family member] needed to go to the hospital it was well-handled and with great care by the staff."

Some of the people who used the service have behaviours that challenge and effective strategies were in place, which included re-enforcing positive behaviours and enhancing people's strengths. This included, for example, the ability to live alone, with staff support, or to find a quiet place to reduce feelings of being upset caused by noise. One support manager said, "Positive behavioural plans give strategies to reduce people's anxieties; to act early on warning signs. To see what you can do to support the person, rather than administer PRN ['as required'] medication." One relative said, "[family member] has calmed down a lot now as the people [staff] who are working with him are very good." One member of staff said that another one of the people had become more settled over the last eighteen months, with their need of the level of staff support decreasing. The registered manager provided another example of the effectiveness of the care provided: they described how one of the people was empowered to become more confident and able to live an independent life in the community comparing this success to when the person was previously looked after in a hospital setting. The registered manager added, "The success is due to the intensive therapy [we provided]."

Good

Is the service caring?

Our findings

The provider told is in their PIR how they ensured people's rights were respected. They wrote, "Staff are employed to empower the people supported and to develop skills to become as independent as possible. The people we support are empowered to make decisions for themselves." One person told us that they liked the member of staff who was looking after them. We saw the member of staff encouraged the person to independently talk with us. We saw another person was enabled to be independent with getting ready to go out after, also, independently clearing up after eating their lunch.

Relatives were satisfied with how their family members were cared for and had positive comments to make. One relative said, "[Family member] needs continuity of staff. And they are getting this. They are really well-looked after." Another relative said, "They [staff] are always thinking about [family member]. [Thinking] what can we do for [family member]?"

Members of staff told us that how they enabled and valued people. The registered manager said, "We don't give up on people and we support people through difficult and challenging times." One support manager said, "The care is about promoting people's independence; to allow people to make choices and have opportunities [for social and community integration]." Relatives told us that they were satisfied with how staff respected their family members' privacy and dignity. One relative told us that staff provided their family member's personal care in private. They said, "It's all done in [family member's] own room."

During our visit to people's homes we saw a range of quality of care. We saw good examples of staff engaging with people in a warm, patient and caring way. However, this was not consistent although the provider had identified this as a key area for improvement in one of the people's homes which we visited. We saw some of the people were supported by one-to-one staff although there was limited, social interaction by them with the person they were looking after. This included, for example, during the time when people were eating their afternoon snack or relaxing. One support manager advised us of changes made, or planned changes that were to to be put in place. They said, "We are fully aware of what needs to be done. We've started but we can't change things overnight." The management of change was aimed to improve the quality of people's care to become person centred and, therefore, respect of the person as an individual. This included, for example, improving how staff ensured that people's confidential information was kept secure and the quality of engagement with people. The registered manager said, "[When I first visited] this [home] it felt very much like a residential care service. We've got to work through changing the culture of staff. The visitors' signing-in book is no longer used. It [the quality of care] is better than what it was." One member of care staff described improvements in the culture of how people were being looked after. They told us that people's care was now provided based on their individual needs, rather than based on institutional, task-driven care.

Relatives told us that their family member's choices about how they wanted to live were valued. One relative said, "They [staff] let [family member] sleep in. Or sometimes they are up when they want to get up." We saw people's choice of what they liked to wear was valued and their preferences were detailed in their care records. One relative told us that they were satisfied with how their family member was supported to wear

the clothes that they liked. They also added that their family member was "always clean and well-dressed." One support manager advised us that people's choices in relation to gender preference of members of staff were always respected. This included, for instance, a request made by relatives on behalf of their family member, for female staff members only to attend to their family member's personal care.

People were supported to maintain contact with their relatives. One relative told us that they visited their family every day. Another relative told us that their family member was enabled to visit them at home.

The operations manager told us that independent general advocacy services were used to enable people to make decisions in relation to the management of their finances. Advocacy services are organisations that have people who are independent and support people to make and communicate their views and wishes.

Good

Is the service responsive?

Our findings

The provider told us in their PIR how they supported people with their complex communication needs. They wrote, "Choice is offered through a person's preferred communication style such as objects of reference, makaton, photos." One support manager advised us that staff members were learning makaton [a form of sign language] to enable them to respond and meet people's individual communication needs. Members of staff had access to pictorial, makaton guidance to support them when communicating with people.

One relative told us that staff understood their family member's complex communication needs. They said, "They [staff] communicate with [family member] very well. They show [family member] a choice of food to point out to. [Family member] will also take them [staff] to show them an object. If [family member] wants a drink, it would be a mug." Another relative said, "You have to know [family member] very well. They use objects of reference, or [family member] shows staff what [family member] wants, by pointing." One support manager said, "Understanding people's communication needs] is by [observing] their body language; or using key words; simple sentences. They may show us objects of reference, such as boxes of breakfast cereal."

Relatives told us that, due to the continuity of staff, staff knew about their family member as an individual. We saw an example of this when a member of care staff spoke with one of the people about their hobbies and interests and what interested them. We also saw that the member of care staff spoke in short sentences, which enabled the person to understand what was being said. Furthermore, we saw that the member of care staff was able to understand and respond to the person's complex communication needs.

Relatives were satisfied with how their family members other care needs were met. One relative told us that members of care staff helped their family with their continence needs and were happy how this was managed. Another relative told us that staff members supported their family member with their sensory stimulation needs.

People were supported to take part in recreational and social activities that were important to them. One relative said, "[Family member] gets a lot of things to do and tries to do a variety of things: swimming; bowling; goes out for lunch; introduction of long walks, as they used to enjoy walking before." Another relative said, "[Family member] goes out. [Family member] keeps very busy." One support manager and team leader described the range of activities people took part in which included work-related activities, eating out and being part of the local community.

People's goals and aspirations about what they wanted to do were recorded, reviewed and monitored. One member of care staff described how one of the people wanted to go on holiday. They were supported to choose where they wanted to go and helped in making their holiday arrangements. The operations manager provided another example of supporting a person's wish to go on holiday to a European capital city and how staff members assisted the person to achieve this.

Before people were provided with their planned care, there was a pre-acceptance assessment to determine

if the service was able to meet the person's needs. The provider wrote in their PIR, "Before supporting individuals, we carry out initial assessments which form the basis of the persons support plan and also helps to identify what risk assessments need to be developed and put in place."

People's care needs were assessed and were reviewed each month or sooner. We found that the assessment, monitoring and reviewing of people's moods was yet to be implemented in one of the people's homes we visited. This assessment tool would enable staff to potentially gain an understanding of, and manage, any triggers that may cause people to become anxious. The operations manager and one support manager advised us that remedial action was to be taken; we saw the team leader was taking this improvement action to formalise an assessment of people's psychological needs.

Other reviews were carried out to gain an overview of the effectiveness of people's care in responding to their assessed needs. People and their relatives were invited to these reviews. The operations manager said, "We would invite people [who use the service] and there would be no restrictions with inviting family members. It would be the choice of the person we support." Relatives confirmed that they were invited, and had attended, their family members' reviews. One relative said, "After the review, there were only minor changes made [to the care plan]." Another relative expanded on this; they told us that their request for continuity of staff had been listened to; their family member had become settled, and "happy", as a result of being looked after by a stable team of care staff.

There was a complaints procedure in place. In their PIR the provider told us that, between 2014 and 2015, they had received one complaint. This was responded to and the outcome reached was to the satisfaction of the complainant. The provider wrote in their PIR, "They [the complainant] were met with and the situation explained and they were happy that we were addressing the issue."

Relatives knew who to speak with if they wanted to raise a complaint, but none had cause to do so. People had access to easy to read and pictorial information in how to raise a concern or complaint if they were able to do so with support from staff. Members of staff were aware of the provider's complaints procedure and how to follow this.

Good

Is the service well-led?

Our findings

The registered manager was trained and experienced to manage the service. They had National Vocational Qualification awards at levels four and five and had over 30 years of experience in supporting adults with learning disabilities. The registered manager was supported by care and management staff and by the provider's range of departments. These included, for example, health and safety and quality assurance departments.

We received positive comments from staff members in respect of the leadership style of the registered manager. One support manager said, "I've seen a lot of changes for the better. In the last two years there has been more structure; improved leadership; improved communication and everyone, people, staff, are being listened to. And we feel valued."

Staff attended team meetings during which they were enabled to contribute to the agenda items. Minutes of staff meetings showed that staff were reminded of their roles and responsibilities in keeping people safe, such as maintaining accurate care records. The meetings also provided staff members to review people's individual needs and any changes that were needed. One team leader advised us that that staffing numbers had increased based on people's individual needs. We were also told that action was taken to improve the availability of private transport to help people gain easier access to the community.

As part of the quality assurance system, auditing and monitoring visits to the service were carried out by different managers, which included the registered manager's manager. Actions were taken in response to findings where improvements were to be made. The provider wrote in their PIR, "Each person supported also has a key quality audit carried out which is more detailed and this generates an action plan for areas of improvement. The actions from these are now monitored as part of the service visits [by the operations manager]." The operations manager advised us that they carried out these visits and these were usually unannounced. Records of these visits were seen and action was taken, if needed. This included educating staff in maintaining people's confidential information. In addition, people were asked for their views about how they were and activities they took part in.

The registered manager described other quality assurance systems: these included sharing information with different departments operated by the provider. Lines of delegated responsibilities were clear and the registered manager was fully aware of their responsibility within this scheme of delegation. The quality assurance systems prompted the registered manager when notifications were required for submission to the Care Quality Commission and we had received such notifications as required. This told us that the registered manager and provider were aware of their legal responsibilities in demonstrating their open and transparency, or 'Duty of Candour.'

The registered manager operated a learning culture and told us how this was developed. They said, "It includes an analysis of complaints and it is also sharing information at directors' meetings. It is a review of lessons learnt and [telling of] 'good news' stories." They also told us how 'lessons learnt' had improved the quality and safety of people. They said, "A lot of checking systems are now in place and we can demonstrate

that we act to minimise the likelihood or the [negative] impact on people." They added that, since they started their role, there were measurable improvements made against the provider's key performance indicators.

Staff were aware of the whistle blowing policy and said that they would have no reservation in reporting any concerns about their colleagues, if they had cause to do so.