Coventry and Warwickshire Partnership NHS Trust

2 Dover Street

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

This inspection took place on 11 April 2016 and was announced. We gave the service 48 hours' notice of our inspection. This was because management and staff could be out. We wanted to make sure they were available to speak with. This service was last inspected on 2 December 2011 when it was found that not all records of individual wishes of tenants are dated or up to date. This was in breach or Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010. We asked the provider to send us an action plan stating how they would improve this. The provider did complete an action plan and we saw at this inspection that all of the actions had been completed.

2 Dover Street is a supported living service registered to provide personal care to people living in their own homes . 2 Dover Street is the office where the registered manager and staff arrange the care for people who live in their own homes. At the time of our inspection there were 12 people who used the service. They received personal care and social support in order to promote their independence.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Recruitment checks were carried out prior to care workers starting work, to ensure their suitability to work with people. Only those staff who were deemed suitable to work with people who used the service were offered employment.

People's assessed care needs were met by suitably trained and qualified staff. Medicines were given by staff who had received specialised training. Their competency to do this safely was regularly assessed.

Staff knew how to keep people safe. They received training to understand safeguarding procedures and how to recognise signs of abuse. They knew to report any suspected incident of harm to the appropriate authorities.

People were supported in line with the principles of the Mental Capacity Act. The manager understood the importance applying for Deprivation of Liberty Safeguards (DoLs) when necessary. Staff ensured they maintained people's privacy and dignity, and treated people with compassion and respect.

Staff knew people's needs, and their levels of independence, well. Appropriate risk management strategies were in place to reduce the risks of people falling, being at risk outside of their homes and receiving medicines. People's needs were assessed by staff who knew them well. Support was planned in a way to ensure that the service was able to safely meet these needs. People and their relatives were involved in this process in defining and agreeing their care needs .

People were supported to see a range of health care professionals.

People had a choice of meals that met their dietary requirements and preferences . We saw that when people were able to staff supported them to prepare their own meals.

Staff had been trained to meet the specific needs of people who used the service. Staff told us they were supported within their job roles.

People and relatives were provided with information about how to report any concerns or compliments. Relatives told us they were confident that actions would be taken in response to complaints.

A range of effective audit and quality assurance procedures were in place. The provider ensured the CQC was notified about events they were required, by law, to do so.

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 knew how to keep people safe. Staff were aware of how to identify risks to people and knew what actions to take to reduce these risks. People were supported by a sufficient number of suitably qualified staff. Staff were available at times when people needed them. The provider's recruitment process helped ensure that only suitable staff were offered employment.

Is the service effective?

Good

This service was effective.

Staff received training to ensure they had the relevant skills and knowledge to support people who used the service . Staff had a good understanding of the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards. People who required support were assisted by staff to eat a nutritional diet based on their needs and preferences. People were supported to attend health care services when it was appropriate.

Is the service caring?

Good

The service was caring.

People's care was provided by staff who showed compassion, respect for people's privacy and dignity. Staff listened and acted upon the views of people in regards to their care and support. People were supported to maintain relationships with family and friends' that were important to them.

Is the service responsive?

Good

The service was responsive.

People's care records were detailed and provided staff with guidance to provide consistent, individualised care to each person. People were supported to actively follow a wide variety of their hobbies, interests and pastimes. People and relatives were aware of how to make a complaint if they had any concerns.

Is the service well-led?

Good

The service was well-led.

Relatives and staff were asked to provide their feedback of the service. Staff felt supported by the management team. The provider had quality assurance systems in place to support them in maintaining a good quality of care for people who used the service.

2 Dover Street

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.

The inspection took place at the service's office on 11 April 2016 and was announced. The provider was given 48 hours' notice because the service is a supported living service. This means staff support people in their own homes. We needed to be sure that staff would be available to attend the office to speak with us. The inspection was undertaken by one inspector.

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 this and information we held about the service. This included the number and type of notifications we had received. A notification is information about important events which the provider is required to tell us about by law.

We spoke with the registered manager and two care workers. We reviewed six people's care records to see how their support was planned and delivered.

We were unable to speak to people who used the service because they did not live at the location we visited. We were informed by the registered manager that people did not have the ability to speak to us by phone due to limited communication skills. After the office visit we contacted two relatives of people who used the service to gain their views of the care provided to their family members.

We looked at six people's care records and medicine administration records (MARs). We looked at records in relation to the management of the service such as checks regarding people's homes environmental safety. We also looked at staff recruitment, supervision and appraisal process records, training records, complaints, quality assurance and audit records.

Good

Is the service safe?

Our findings

Relatives we spoke to told us that they thought their relatives received safe care. One relative told us "I have never worried about their safety since they have been here. They have a good, safe level of care."

Staff were confident in their knowledge about the different types of abuse and how these were recognised. A member of staff told us they completed yearly training about how to protect people from abuse. Staff knew to report any suspicions of harm or poor care practice to their manager or to the local safeguarding authority.

Risks related to people's health and social care needs had been assessed, and actions taken to reduce the risk. These included assessments for people with behaviours which challenged others, accessing the community and risks when moving people who needed assistance to move. These risk assessments were reviewed regularly to ensure they continued to reflect people's needs. People were supported to take risks in a safe way and staff had read the detailed information about the steps that were in place to support people with their safety. For example, where people's behaviours might upset or frighten others, it stated what might trigger a person's behaviour change and what calming measures worked best for each known situation.
The provider also undertook other risk assessments to assist the safety of staff and people. These included checks to help ensure that people's homes were a safe place for staff to work in; and included the safe storage of people's medicines.

People were supported by care staff they were familiar with. A relative told us "I know them [Staff] all by name, I regularly visit at least once a week." The registered manager told us that if the regular care staff were ill or unable to cover a shift then another staff member who knew the person would be used. Relatives confirmed to us this happened. A member of staff told us "There are always enough staff; we don't use agency staff which means people know who is looking after them." Relatives told us there was sufficient staff to meet people's assessed care needs. For example, one relative told us that their family member always had two members of care staff supporting them during the day. "I know they can become easily agitated, so having the right number of staff really provides a calming influence for them."

The registered manager told us the service used a dependency tool to calculate how many staff were needed and this changed depending on individual's needs. Staff rotas showed that staffing was in line with the dependency tool calculations.

Accidents and incidents were recorded. These included times when people had fallen, or whose behaviours had changed and challenged others. Care staff discussed specific triggers for people's behaviours and the calming techniques and measures required. For example, this might include moving to a quieter room. Staff knew what calming measures worked for each person. Actions had been taken to reduce the chances of any recurrences. This included liaison with the person's GP for alternative medication options as well as mental health team interventions.

Steps were taken to ensure people employed by the service were suitable for the role. The registered manager told us, "We only recruit staff who are suitable, and not just to have the right number of staff." A member of staff explained that during their recruitment process they spent an afternoon meeting people who used the service. The registered manager told us this was to assess how potential staff interacted with the people that they would be supporting and to make sure that their, "Personalities were compatible."

The recruitment process also included an interview, obtaining references from previous employers and a DBS (Disclosure and Barring Service) check. The checks were completed to ensure people who were employed were of good character; and to check whether they had a criminal record which might mean they were unsuitable to work as a care worker. This was in line with the provider's recruitment policy.

People were supported to take their medicines in a safe way. Medicine information included an alert for staff about medicines people were allergic to and medicines which had to be taken at specific times of the day. This was important so that all staff knew how to give people their medicines correctly. A relative told us the person was "always given the medicine they need. I've never had any problems with that." Each person's medicines administration records (MAR) contained the information specified by the prescriber. Staff were trained, and assessed as being competent in the safe administration of medicines. The manager undertook regular observation of all staff who administered medicines to check that their knowledge and practice was safe. Staff were able to tell us the support each person required with their medicines.

Good

Is the service effective?

Our findings

People were supported by care staff who had the necessary skills, and who knew the people they cared for well. A relative told us, "They [staff] are very good at their job. They are very professional and know how to look after my family member in the way that [Name] likes."

The registered manager explained new staff had an eight weeks induction period. During this time they undertook The Care Certificate training, and worked alongside more experienced members of staff. The Care Certificate is a nationally recognised training standard for social care to give health and social care workers the knowledge and skills they need to provide safe and compassionate care. The provider used this as a benchmark that staff were expected to achieve. One member of staff told us, "I was really well supported with my induction. I had to complete a workbook of my training and I shadowed other members of staff to get to know people's needs."

All staff had received training and regular updates in subjects such as, but not limited to, infection control, dementia care, food hygiene, moving and handling and the Mental Capacity Act 2005 (MCA). The registered manager's training matrix showed that all staff training was up-to-date. One member of staff said, "We are reminded when our training is due and this gives us time to book on to training." By regularly renewing their training it helped to ensure practice remained in line with current guidelines.

Staff told us they were supported and encouraged to undertake recognised qualifications in care, to better develop their care skills and provide a higher standard of care for people who used the service. The registered manager ensured the majority of staff had completed nationally recognised care qualifications (NVQ) and that plans were in place to ensure that all staff received this training.

Staff had regular one to one meetings with their manager. They told us this gave them the opportunity to discuss their training and development needs. One member of staff told us they had asked for support with their maths and English and their manager had arranged for them to complete a course to improve their skills.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this must be made through the Court of Protection for people living in the community.

The service worked within the principles of the MCA. We found that the registered manager and staff had an understanding of the MCA and Deprivation of Liberty Safeguards (DoLS). The MCA protects people who might not be able to make informed decisions on their own about their care or treatment. Where it is judged that a person lacks capacity, a person making a decision on their behalf must do this in their best interests

and in the least restrictive manner. A relative told us a meeting had been held to discuss decisions which needed to be made in the person's best interest because they could not make them for themselves. The person's social worker and staff also attended the meeting. The relative told us, where the person had the capacity to make decisions, that staff respected their wishes. They said, "Yes. Definitely. They always offer choice and support [Name] to do what they want."

Care records showed which decisions a person could make and what information the person could retain. For example, the type of clothes the person liked. Staff ensured the care provided was only with the person's agreement and in line with the MCA code of practice. One member of staff said, "Although we always help people, we can't make them do things. It's their choice."

We looked at how people were supported to eat and drink . When people were able staff supported them to prepare their own meals and drinks. Other people were provided with meals and drinks which met their nutritional needs and preferences. People were provided with a choice of meals. A relative told us about the food their relation received; "It all looks very good and not all junk food." They went on to explain that their relative was offered choices and that, "Carers know what [Name] likes and dislikes."

Staff understood the foods people liked, how and where they liked to eat their meals, and any dietary needs. One person enjoyed making their own meals and staff had made a folder of recipes with step by step photographic instructions. This allowed the person to independently choose and prepare food that they enjoyed. Another was fed through a PEG (Percutaneous endoscopic gastronomy). This is when a person is unable to swallow food and instead is fed through a tube into their stomach. The member of staff told us all staff who supported this person had received specialist training so that they knew how to give these meals safely.

Relatives told us that people who used the service were supported to attend health care appointments. Referrals were made to health care professionals including a dietician, speech and language therapists and community nurses.

Good

Is the service caring?

Our findings

Relatives and staff told us that the service was caring. One relative told us "They [staff] are all really patient and caring and that's really important to me."

Staff respected people's privacy and dignity. A relative told us, "[Name] is always clean and well-dressed when I visit and they always take them off to the toilet and insist [Name] shuts the door when they need to go." Another relative told us, "The staff are so good with my relative; they treat [Name] just how you would want to be treated. They're very respectful." Staff told us that they always knocked on people's doors, made people aware of their presence and gained permission before entering their bedrooms.

People were supported to be as independent as they chose to be. A member of staff told us "It's important to ask "Can I help you" before you automatically help someone. I wouldn't want someone interfering if I was doing something so I always ask if someone wants help before assuming."

Staff understood what a person could do on their own, and what they needed help with. For example, when providing personal care, if the person could wash their face, staff would enable them to do this. They would then wash the remaining areas the person could not do. One relative told us their family member enjoyed visiting different places but was unable to do this on their own. They went on to explain that care staff accompanied the person and this enabled them to visit the places they wanted to go to.

The PIR told us people were involved in each stage of their care and people signed their care plans to say they agreed with the discussions. It explained that relatives and people were fully involved with the review of people's care, and where necessary, advocacy services were used. It also explained that a worker (key worker) was assigned to this process who would discuss any changes required with the person or their family. The care files we reviewed were signed by the person using the service or if the person did not have capacity, a family member signed on their behalf. The registered manager confirmed advocacy arrangements people had, such as lasting power of attorney for people's financial affairs. Advocates are people who are independent of the service and who support people to make decisions and communicate their wishes. Relatives confirmed that this process was followed and that they were regularly updated by their family member's key worker. One relative told us "I'm invited along to regular meetings to discuss my relative's care."

Staff knew how to communicate well with people who could not communicate verbally. In care files we saw "communication passports" which were personalised documents describing common gestures or noises a person used to communicate and what each one meant. Staff were able to describe to us how the people they supported communicated with them. A member of staff explained "[Name] cannot talk to us but they understand us. If you ask question with a 'yes' or 'no' answer, they will smile to indicate yes or compress their lips to say no. Another person uses points of reference to tell us what they want. They will point to a cup if they want a drink or go and get their dressing gown if they want a shower. If they want to go out they will go and sit in their wheelchair."
Relatives told us that staff supported people to stay in contact with them such as assisting them to make

phone calls. We were also told by staff and relatives that people were supported to meet their friends outside of their home. This helped to support people to maintain relationships with people that were important to them.

Good

Is the service responsive?

Our findings

People received individualised care and support. Each person had an individual care plan which detailed what was important to them, their preferences, values and beliefs. Initial plans were completed using an assessment as well as information from the local authority. People's care plans contained detailed information based upon each person's needs for example, one care plan stated "I get anxious if I don't understand. When I'm anxious I rub my hand and look down. Please talk to me in a clear tone, if I do not respond ask me later or put it another way." These plans ensured staff, especially new staff, understood individual people needs and how to support them. Staff told us that they found the care plans easy to follow and that these could be referred to at any time.

People were supported to take part in activities they enjoyed and were meaningful to them. A relative told us "[Name] loves going out in their car and the carers know this and will take him different places so [Name] has different stimulus." Staff were knowledgeable about the individual preferences of each person. People were supported to take part in individual activities they enjoyed. These preferences were recorded in their care files. A member of staff explained that "[Name] enjoys beauty treatments like having their nails painted. Another person enjoys going out shopping or for a coffee." The registered manager told us that people who lived in two houses close to each other regularly went to one house to have a meal together. This was because people had formed close friendships and enjoyed each other's company.

Staff were aware of people's changing health needs and actions which needed to be taken. This was because notes were written daily about the care given to people and important information was shared between one staff team finishing their work for the day, and the next team on duty. When needs changed, care plans were updated. For example, after a person had been admitted to hospital, staff obtained relevant information to update their care records. This described how the person's needs had changed and helped determine any new equipment requirements and if any additional training was required for staff.

The service had a complaints policy and procedures, and a copy of this was available for people who used the service. Easy read versions which included short sentences and images were available for people who were not able to understand large amounts of text. The leaflets included details on how to contact other organisations such as the CQC, local safeguarding authorities and the Local Government Ombudsman.

Relatives told us that staff gave them information about how to raise complaints and they were aware of the provider's complaints policy. No complaints had been made in the past 12 months. However a relative informed us that in previous years they had made a complaint and was very satisfied with the way the manager had dealt with it.

Good

Is the service well-led?

Our findings

The service had a registered manager. The provider is required, by law, to notify the CQC of certain important events that occur at the service and in people's homes. From records viewed we found that they and the registered manager had notified us about these events where required.

Relatives told us they knew who the registered manager was, one stated the registered manager "is always very easy to contact and speak to and she listens to your concerns and will do something about them."

The registered manager involved people in the development of the service. Service satisfaction surveys were sent to relatives and health professionals. We reviewed the results of the most recent surveys and found they indicated high levels of satisfaction with the service. Written comments included "I think you have done a great job in the house. When I phone I get a cheery answer." Another comment described where a person lived had a "happy environment." No suggestions for improvement had been made in the surveys. However one comment reflected on the positive impact a change had made "[Name] is much happier now that they have all male carers." A change from female carers allowed the person to feel more comfortable during personal care. A relative told us that it had been identified by staff that a person's bathroom was no longer suitable for their needs. The relative explained that the manager had acted on the concerns of staff and that changes had been made to the design of the bathroom which made it more accessible.

Staff were involved in the continuous improvement of the service and had opportunities to provide feedback in team meetings which were held regularly. These meeting gave staff the opportunity to discuss general themes such as the sharing of good practice. We were told the meetings also allowed people to discuss events in the local area and any new training courses staff might wish to go on. One staff member said, "We get given information at meetings but we can also raise any aspects that we feel could be improved. The manager is very good at listening to our suggestions and will always see if they can be put into practice."

The registered manager completed checks to ensure that care provided by the service was safe. Spot checks on staff's performance were undertaken frequently at people's homes. These checks enabled the manager to keep in touch with people and to make sure staff worked to the correct standards. They included staff's adherence to any changes to policies or working practices as well as ensuring staff correctly completed documentation. The registered manager also regularly visited people's homes to monitor the day to day culture of staff and offer any advice and guidance needed as well as providing praise on the things staff did well.

A range of audits and checks took place to assess the quality and safety of service provided. This included checks on the premises to ensure they were safe, and checks on the quality of care people received. We saw actions were taken to address any shortfalls. For example, in one house, looped chords hanging from window blinds had been identified as a strangulation risk. Actions were immediately taken to remove the risk. Plans had been made to replace these blinds with ones that did not have hanging chords.

The provider was also involved in assessing the quality and safety of the service provided. They analysed the incident reports, audits and training records, and fed back to the registered manager actions required in response to the analysis. We were told the provider formally met with the registered manager every three months but they had more regular meetings to discuss the day to day running of the service.

The provider's policies and procedures were clear and comprehensive. The policies were updated regularly and included latest research so that best practice was delivered to people. Staff told us when policies were reviewed; they were informed and would read them. Staff told us if they were unsure of changes to policies they could discuss this with their manager or team leader and would receive clarification.

The registered manager supported staff with regular on to one meetings and appraisals. These gave staff opportunities to ask advice and to plan how they would further develop their skills. All staff commented very positively about the support that management provided. One member of staff said "If I ever need support their door is truly always open. I can share ideas or concerns with them even my personal life if it affects my work and [registered manager] listens and acts to help me and my work."