United Response

Felpham DCA

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

The inspection took place on 26 and 28 July 2016 and was announced.

Felpham DCA provides personal care in a setting called 'supported living' in three locations in the Felpham and East Preston area. Supported Living is a scheme where people live in their own homes and are supported to be independent by a team of care staff. Care was provided to 12 people aged from 57 to 86 years.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse. People said they felt safe with the staff.

Care records showed any risks to people were comprehensively assessed and there was good guidance of how those risks should be managed to prevent any risk of harm.

Staff were provided in sufficient numbers to meet people's needs and provided care at times agreed with people.

People received their medicines safely.

Staff had access to a range of relevant training courses, including nationally recognised qualifications. Staff were supported in their work and received regular supervision from their line manager.

Staff were trained in the Mental Capacity Act 2005. The registered manager knew the responsibilities of assessing people's capacity and when to seek advice by referring people to the local authority where there was an issue regarding people's capacity to consent to their care and treatment.

People were supported with shopping and the preparation of their meals.

People's health care needs were assessed, monitored and recorded. Referrals for assessment and treatment were made when needed and people received regular health checks.

Staff had positive working relationships with people and were observed to have a good rapport with them . People were consulted about their care and staff used communication tools to find out what people wanted. Care was provided by staff who sought to promote people's independence and valued the people they provided care to.

Assessments and care plans were comprehensive and of a very good standard with close attention to detail which ensured care was 'tailor made' to meet individual needs and wishes. We call this person centred care.

People were supported to attend a range of activities, which included employment, hobbies, social events, holidays, day trips and attendance at the theatre and opera.

The service had a complaints procedure and people said they knew what to do if they had a complaint. The service encouraged people to express their views and any concerns, which were recorded and acted on.

There was a good standard of quality assurance at the service and people were involved in various aspects of the running of the service. People and their relatives' views were sought as part of the service's quality assurance process.

There were also a number of systems for checking the safety and effectiveness of the service such as regular audits.

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.

The service had policies and procedures on safeguarding people from possible abuse. Staff knew what to do if they suspected any abuse had occurred.

Risks to people were assessed and guidance recorded so staff knew how to reduce risks to people.

Staffing was provided to meet people's assessed needs.

People received their medicines safely.

Is the service effective?

Good

The service was effective.

Staff were trained in a number of relevant areas and had access to nationally recognised qualifications in care. Staff were supported in their work and received regular supervision.

Staff were aware of the principles and procedures as set out in the Mental Capacity Act 2005 Code of Practice and worked collaboratively with local authority social workers if there was an issue about people's capacity to consent to their care and treatment.

People were supported with preparing meals and to have a healthy diet.

Health care needs were monitored. Staff liaised with health care services so people's health was assessed and treatment arranged where needed.

Is the service caring?

Good

The service was caring.

Staff had good working relationships with people and demonstrated they treated people with dignity. People felt valued by the staff.

People were supported to develop independent living skills.

Care was provided based on each person's preferences and wishes.

Is the service responsive?

Good

The service was responsive.

People's needs were comprehensively assessed and reviewed. Care plans were detailed and of a high standard in reflecting people's preferences.

People were supported to attend a range of activities of their choice including employment and holidays.

The service had a complaints procedure and encouraged people to express their views about the service.

Is the service well-led?

Good

The service was well-led.

The service used a number of methods to obtain the views of people as part of its quality assurance process. There were arrangements which empowered people to make decisions about how the service ran.

There were a number of systems for checking and auditing the safety and quality of the service.

Staff worked collaboratively with other services such as community nursing teams so people received a coordinated approach to their care.

Felpham DCA

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. The inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 26 and 28 July 2016 and was announced. We gave the provider 48 hours notice of the inspection because it provided personal care to people in their own homes so we needed to be sure the registered manager or staff were in the office.

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 any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

The inspection was carried out by one inspector.

During our inspection we looked at care plans, risk assessments, incident records and medicines records for four people. We looked at supervision, training and recruitment records for three staff and spoke to four staff as well as the registered manager. We also looked at a range of records relating to the management of the service such as staff rotas, complaints, records, quality audits and policies and procedures.

We spoke with five people who received a service from Felpham DCA to ask them their views of the service they received. We also spoke to two relatives of two people. We observed staff interacting with people in two of the supported living services.

We spoke to a social worker who was involved with the service and a community nurse who provided care to someone. We also spoke to a commissioner from the local authority who monitored standards at the service as part of their contractual arrangements. These professionals agreed their views on the service could be included in this report.

The service was last inspected on 14 April 2014 when no concerns were identified.

Good

Is the service safe?

Our findings

People told us they felt safe when care was provided by the service. For example, when we asked one person if they felt safe, they replied, "I feel 100% safe. Never felt safer." Another person said they felt safe when they received support with care such as being assisted to transfer and when out with staff in the community. People said they knew how to raise any concerns they might have. Health and social care professionals also considered the staff provided safe care. People said they received care from a staff team who they knew them well and who were reliable. For example, one person said, "I have care staff at set times and they are always punctual. Yes they are skilled and communicate well with me."

The service had policies and procedures regarding the safeguarding of people, which were prominently displayed in a flow chart on the office wall. The registered manager showed us the system for recording and reporting any safeguarding concerns. Staff also had access to local authority safeguarding procedures. Staff training was provided in safeguarding procedures and senior care staff and the registered manager attended additional more advanced training in safeguarding people. Staff were aware of their responsibilities to report any concerns by either speaking to their manager or using the 'whistleblowing' procedures or contacting the local authority safeguarding team.

The provider confirmed their approach to risk by the use of 'positive risk management,' which was described in the PIR: to 'enable individuals to take control where possible and to achieve the things they wanted to do whilst minimising risk.' This approach was clearly reflected in the risk assessments and in how people were supported. People's care records included assessments of those aspects of people's daily life where a risk was identified. These were comprehensive and gave staff information they needed to ensure people were safe. Care plans included guidance for staff to follow to mitigate against risks to people. For example, one person's care plan included step by step guidance on how to safely move and transfer the person. In addition to this, there was information recorded of how staff should recognise the person may be uncomfortable when being moved, such as getting hot and having a flushed face. There were risk assessments regarding people undertaking activities of daily living such as using kitchen equipment to prepare meals. This ensured people were able to exercise independence whilst being safely supervised. Guidelines were recorded to safely support people with activities such as swimming. Risks when providing personal care to people were assessed with corresponding guidance on how to keep people safe, such as people with epilepsy having a bath or shower. Details about risks regarding behaviour were assessed along with care plans of how to minimise the risks. The risk assessments were reviewed on a regular basis.

Arrangements for supporting people with their finances were assessed using a risk assessment. Referrals were made for assessment by the local authority where people were not able to safely look after their finances. Where people were supported with their finances this was clearly recorded so staff knew what to do. There were systems of receipts, checks by two staff and a signature to show where the two staff supported people with their finances.

Staff were trained in the safe moving and handling of people as well as in assessing risks and in fire safety. The provider confirmed health and safety checks were carried out on any equipment used.

There were separate staff teams for the two supported living schemes which most people lived in. One person was provided with between one and two care staff over a 24 hour period for seven days a week which was provided in their own home. These staff hours were organised on a duty roster. In one of the supported living schemes there were between two and four staff on duty between the hours of 6.30am and 10pm plus a member of staff on a 'sleep in' duty. This was for five people. In another supported living scheme staff were assigned to work with people based on specific hours each day and staffing was organised on a duty roster. The staff hours recorded on the duty roster reflected the hours planned as being needed to meet people's needs. People told us there were enough staff to look after them safely. Health and social care professionals also considered there were sufficient staff to meet people's needs but one professional said there had been issues regarding the care of people who needed support at night as the night staff role was to deal with emergencies and not providing care at night time. This professional said this was resolved after discussion and agreement with the staff.

Staff said they worked well as a team and supported each other. Whilst staff felt there were enough staff to meet people's needs they also commented that there were a number of vacancies which meant agency staff were sometimes used to cover for any vacancies. The registered manager acknowledged the difficulties caused by staff vacancies and confirmed new staff were being recruited to the vacant posts.

We looked at the staff recruitment procedures. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. There was a record of newly appointed staff being interviewed to check their suitability. The registered manager told us people were directly involved in the recruitment of new staff and had an opportunity to give feedback on whether they considered people were suitable or not. This ensured the provider only employed staff who were suitable to work in a care setting.

The service had policies and procedures regarding the ordering, storage and handling of medicines. People said they were supported to take their medicines when they needed them and some people were independent in this. Staff were trained in the safe handling of medicines, which involved observation of staff competency to do this. Medicine administration records (MARs) showed staff signed to acknowledge medicines were administered to people, or people were supported to take their medicines. We noted one person's MARs did not have a staff signature to show staff had administered the medicines as prescribed on one occasion. This was discussed with the registered manager and deputy manager who acknowledged this was an oversight by a staff member and would be followed up. Any errors identified in the handling or administration of medicines had been looked into to prevent any reoccurrence. People's support needs regarding their medicines were assessed and recorded in care plans and there were records to show people's medicine was reviewed by their GP.

Good

Is the service effective?

Our findings

People said they received care from staff who were skilled and knew what their needs were. For example, one person said the staff were skilled in communicating with them. Another person said the staff supported them well, adding, the staff "provide care in the way I want and are on time."

People confirmed they were consulted about their care which was reflected in people's care records. People said staff supported them to get the right health care and helped them to attend medical and hospital appointments.

Newly appointed staff received an induction to prepare them for their role, which involved enrolment on the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standard that should be covered as part of induction training of new care workers. The induction also involved newly appointed staff working with experienced staff in a 'shadowing' role. The induction procedure included observational assessments of staff competency.

Staff training consisted of a combination of class based and interactive IT courses. For example, training in moving and handling, first aid and supporting people with behaviour needs were class room based whereas courses in safeguarding people, equality and diversity and dementia were completed by staff using an interactive IT programme. One staff member said the interactive courses did not take account of specific staff needs and the registered manager said how additional support was given where this was the case. Senior and management staff were trained in supervising staff. Staff also had access to nationally recognised training qualifications such as the National Vocational Qualification (NVQ) in care and the Diploma in Health and Social Care. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. The provider confirmed nine of the 15 staff were trained to NVQ level 2 or above. Staff considered the provision of training was good and said their training needs were monitored and discussed at supervision.

Staff confirmed they received regular supervision and felt supported in their work. Records of supervision were maintained to a high standard and showed staff supervision sessions covered various aspects of each staff member's performance and their work. Annual appraisals were also comprehensive and recorded to a high standard. Regular opportunities for staff supervision ensures staff skills are monitored and that good practice is consistently delivered.

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.

The service had policies and procedures regarding the Mental Capacity Act 2005 and tools for assessing the

capacity of people who were unable to consent to their care and treatment. Staff were trained in the MCA and were aware of the principles of the legislation and the need to gain the consent of people before providing care. The registered manager was aware of the procedures to follow when someone did not have capacity to consent to their care and the process of making 'best interest' decisions on behalf of people. People said they were consulted about their care and that staff asked them how they wished to be helped. Care plans showed people's views were sought in how they wished to be supported. The care plans gave staff guidance on how to communicate with people to find out what they wanted and the support people needed to make a decision. A social care professional said staff supported people to make decisions by providing the right information in a way they understood and gave an example of this regarding medical treatment.

There were records of monthly meetings with people and a staff member, which showed people were consulted about their needs and preferences. There was a discussion with the registered manager about the provider's system of gaining people's consent and when an assessment of capacity was needed. This was not based on people's capacity to make specific decisions but on the person's ability to agree to their overall care plan. The registered manager agreed this did not appear to follow the guidelines of the MCA and the provider may find it useful to review this further.

People were supported to eat a nutritious diet. People told us they were able to make a choice about the food they ate and said they liked the food. Support was provided to people with meal planning and the preparation of food. We observed staff supporting and supervising people to make a hot drink. Staff told us how each person was supported to go shopping to buy food and to prepare the food. This enabled people to maintain and develop their independence. We observed fresh fruit was available to people in a supported living service.

People's health care needs were assessed and showed arrangements were made to support people with dental care, annual health checks and more specialist medical appointments. There was a document which could be used to accompany people to hospital so important information about the person was passed on. Each person had a 'Health Action Plan', which included details about health care needs and how people were supported to manage conditions such as continence, pain, weight, fluid intake and dental care. There were reports from health care professionals such as occupational therapists and community nurses so the staff had guidance on how to support people. Records also showed how a community nurse was pleased with the support provided by staff regarding a specific medical need. This was also confirmed when we spoke to the community nurse. Staff liaised with health care services and referred people for medical assessments and treatment when required. A social care professional also commented that staff supported people well with their health care needs.

Good

Is the service caring?

Our findings

Staff had positive working relationships with people and said staff treated them well. For example, one person said of the staff, "They treat me like a human being….with kindness and warmth." Another person spoke of having good relationships with staff who were described as, "friendly." People told us they were consulted about their care and conversed with them to find out how they wanted to be helped. People told us staff acknowledged and promoted their independence, which they said was very important to them. Staff supported people to access community facilities.

Staff were observed to get on well with people and there was a good rapport between staff and people who talked freely to each other. We observed staff had a good knowledge and understanding of each person's needs and preferences, which included knowing how to communicate with people. Care plans gave staff guidance on how to communicate with people and how to support them to make decisions.

Staff told us how they treated people as individuals by providing person centred care. They said it was their job to ensure people had choices and to support people could to attain their own desires and goals. Staff also said they treated people with respect and dignity and as they would like to be treated themselves.

People said staff knew their moods and helped them when they were upset. For example, one person said, "The staff know my moods. When I am happy and when I am upset." Another person told us how staff noticed when they were upset or low in mood adding, "They cheer me up."

Staff were trained in person centred support and people's care plans were recorded to a good standard demonstrating there was attention to detail to ensure care reflected what people wanted. Care records reflected a commitment to people's rights to lead a life of their choice. For example, information was recorded under headings such as, 'My Life and How I Like To Live It,' and, 'What I Spend My Money On.' A social care professional said staff were, "very caring" and treated people in a way which made people feel valued.

Care plans showed people were able to choose how they spent their time and how staff promoted dignity and privacy. For example, one person's care plan said, 'On days when he is going out knock on his door at 7am and wait to be invited in. When he isn't going out knock between 8-8.30am.' Staff were observed to knock on people's doors and to wait for a reply before entering. Care plans gave clear details of how staff should support someone and those tasks people could do themselves so their independence was promoted.

The provider informed us people were able to choose the gender of the staff who supported them and care plans included a 'staff matching tool' to assess which staff would be the most suitable to work with each person.

People's spiritual needs were addressed which were recorded in care plans and people were supported to attend church if this was their choice.

The PIR highlighted how the staff and registered manager identified some people were entering the latter part of their lives and that arrangements for any end of life care were discussed with people. These were recorded in people's care plans and showed personal preferences were included. The provider also told us how they worked with other professionals regarding any end of life care people may need.

Good

Is the service responsive?

Our findings

People said they were involved and consulted in the assessment of their needs and in how they received care. For example, one person said, "most of the time I get the care I want at the times I need it." People said the care was reliable and that staff arrived at the times agreed with them. It was clear from discussions with people and staff that arrangements for supporting people were 'tailor made' to reflect what the individual person needed and wanted. Relatives said they were satisfied with the care provided. One relative said the staff "go the extra mile" to take care of their relative.

People said they were supported to pursue their own interests and hobbies as well attending activities such as day care, social outings, holidays and employment.

The written assessment of people's needs and the care plans of how those needs were to be met were of a high standard as they were comprehensive and reflected person centred care. For example, information was recorded under headings such as 'What Is Important To Me,' 'How I Like and Need My Support,' and, 'How I Will Stay in Control of My Own Life.' Care plans paid close attention to various scenarios and eventualities. For example, one person's moving and handling care plan gave staff details of facial expressions to indicate the person was stressed by the process and what staff should do to calm the person. Another example included very detailed guidance to support when shopping for confectionary as follows: 'Remember to divide sweets into separate bags explaining to her/him what you are doing so she/he doesn't get upset. Put them in her/his box in the cupboard and give her/him some to put in her bag.' This level of detail demonstrated an understanding of people's needs and ensured people received support that was meaningful to them.

There was a comprehensive assessment of each person's ability to communicate along with guidance of how staff should interact and respond to find out what people wanted. These included details recorded under headings such as, 'How I like information to be given to me to help me understand and make a choice,' and, 'These are the best times to ask me to make a decision and these are the times you shouldn't ask me to make a decision.' This demonstrated careful consideration to ensure people were fully involved in contributing to decisions about their care.

Health and social care professionals said the staff were responsive to meeting care needs but one professional stated there had been some initial reluctance to change working practices to meet the needs of one person as they got older. This included care practices regarding continence care and knowledge of procedures for managing pressure areas on people's skin. The healthcare professional said these were resolved by discussions and guidance to staff. We spoke to the registered manager about this who was unaware of any difficulties being expressed by the healthcare professional and said the person's care was reviewed with the professional and arrangements for the care of the person agreed in a care plan.

Staff were trained in person centred care and there was a regional Practice Development Coordinator who was qualified in providing support based on person centred principles. This staff member was involved in providing advice and support to staff in person centred care and person centred thinking to ensure this was

embedded in practice.

Staff used a 'daily planner' document in the supported living services, which included details of any outings which staff supported people to attend, other daily activities, shopping trips with people and the arrangements for meals. Monitoring forms were used to check people received personal daily care such as assistance with toileting, oral care and nail care.

Care plans included details of activities and social needs people were involved in. These showed people were supported to lead a fulfilling lifestyle of their choosing. The service had its own transport for taking people out to events. People attended educational and occupational activities such as college courses, arts, crafts and employment. Each person was supported to have a holiday of their choice accompanied by staff; these varied from trips abroad to more local places depending on people's choice. Leisure activities were assessed and reviewed in people's care plans in a document called 'Outcomes Support Plan.' Leisure activities included the cinema, opera, theatre shows, attending football matches and day trips. One of the people we spoke with said they were looking forward to a forthcoming trip to London to see the 'Changing of the Guard' at Buckingham Palace followed by a theatre performance and that they had enjoyed a recent holiday in Italy. A social care professional said people were supported to take part in activities of their choice.

Staff said people received care which reflected people's needs and enabled them to be independent. For example, a member of staff described the service people received as "amazing" where people had their own tenancy and were supported to live independently with the support of staff.

The service had a complaints procedure which was also in an easy read pictorial format so people could understand it. People had one to one meetings each month with a member of staff which included a discussion about people's care needs and any concerns they had. One of the people we spoke with said the monthly reviews allowed them to raise any concerns which were then resolved. Issues or concerns raised by people or their representatives were recorded in a feedback file and showed what action staff had taken to make any changes. People said they felt able to raise any concerns they had and said staff listened to what they said. The service maintained a record of any complaints and of the action taken to look into and address any concerns. The service also maintained a record of any compliments and these included people and relative's satisfaction regarding activities and holidays provided for people.

Good

Is the service well-led?

Our findings

People told us they were able to talk to staff about their experiences of the service. One person told us they had a role called a 'Quality Checker' which involved visiting people in other services run by the provider to ask them for their views. The document completed by the 'Quality Checker' was comprehensive in the areas it covered. This was used by the provider as part of its quality assurance process to find out the experiences of people.

People's views about the service were also sought by a survey questionnaire as part of the quality assurance process. The surveys were also provided to people's relatives to complete. Results of the surveys were compiled on a regional basis. The registered manager was given copies of the survey results for Felpham DCA which showed only positive comments. The provider also sought the views of staff by using survey questionnaires. Staff said the service's management were open to staff suggestions or comments. For example, a staff member said how they felt supported in their work and could raise any issues they had, adding, "I can say whatever I want." Staff also said the regular team meetings allowed them to discuss the care of people and how the service ran. Records of staff meetings were maintained and showed staff were able to suggest items for discussion

Management were aware of the day to day culture of the service and kept this under review. Staff demonstrated a set of values which included treating people with compassion and independence. The service's management reviewed staff performance to ensure the service's values were promoted; this included observations of staff working with people. People also took a role in contributing to staff performance reviews when they were asked to give their views on the individual staff who provided support to them.

The service had a registered manager who was aware of their responsibilities. The service had two senior care staff who supervised care staff at one of the supported living services. At another supported living service there was a senior care staff member with responsibility for supervising care staff. Staff told us they felt supported and had access to management support when they needed it. The registered manager also carried out care duties and was included on the staff rota to provide care. He said this enabled him to work alongside staff and people which enabled him to have a fuller understanding of any care issues.

There was a system of oversight and governance by the provider, which included an audit of the service by a registered manager from another service operated by United Response. These audits covered staff supervision, staff skills, risks to people, checks on the management of finances and, observations of staff working with people. The registered manager also carried out weekly and monthly audits, which was submitted to the provider. There were action plans for any improvements which were identified as being needed. An area manager also carried out regular visits to the service which included a six monthly audit and audit report.

The service was audited in 2016 by one of the commissioners from the local authority as part of their contractual arrangements with the service. This was very positive about the performance of the service and

concluded, 'This monitoring visit has found evidence of high quality supported living provision and management."

The provider said the service worked collaboratively with other service providers such as local community nursing team. A community nurse described how they worked with staff to ensure people received safe and effective care.