Torbay and South Devon NHS Foundation Trust

St Edmunds

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

Overall summary

St Edmunds was registered under Torbay and Southern Devon NHS Foundation Trust (the Trust) in October 2015 as a location from where adult social care was delivered. This was the first inspection of St Edmunds under this provider, although the service had been established for many years as a location under the previous Care Trusts registration.

The inspection was announced and took place on 8 and 9 February 2016. We gave 48 hours notice of our inspection to ensure that the registered managers and staff would be available to meet with us.

The registered location of St Edmunds is the base for two Adult Social Care teams, called the crises response team (CRT) and re-ablement /intensive home support service(IHSS) Each of these services had a separate registered manager, and performed a different function, but worked closely together.

The CRT was a small team of staff available at very short notice to support people in their own homes. This might for example be in the case of a care breakdown or to provide emergency support until a more permanent care package could be organised. It could be for as short a

Summary of findings

period as a couple of hours to resolve a crises. They also operated a short term night sitting service for people at significant risk in their own home until other services could be provided.

The re-ablement/IHSS team provided an intensive support service for up to six weeks to help people in their own homes maximise their independence, for example following a stroke or a stay in hospital. This might then be followed by a more permanent care package from another provider.

People who received a service might include younger people with physical support needs, as well as older people, some of whom may be living with dementia or long term health conditions. At the time of the inspection the CRT was providing care for nine people and the IHSS team for 16, however these figures changed every day dependent on referrals received. Frequency and length of visits varied depending on people's individual needs. For example some people were receiving calls of an hour to support them to re-learn how to use stairs safely in their property, and another person had received crises support overnight.

People's safety was considered when providing a service. Risks to the health, safety or well-being of people who used the service were assessed and managed where possible. Where the teams from St Edmunds did not undertake risk reduction plans, staff were aware of how to escalate concerns about people's well-being to other agencies. These would include district nurses for example who would be responsible for managing any wound care. They would be responsible for carrying out their own risk assessments of risks associated with people's care. Staff understood about abuse and what they needed to do to protect people from abuse. The Trust had systems in place to ensure concerns were escalated and investigated.

Staff were protected in their working role. There were enough staff to support people, and policies were in place and well understood to reduce risks to staff working in the community with people potentially in crises. Robust recruitment procedures were in place and there were sufficient staff to ensure people's needs could be met. The service had flexibility to meet unpredictable demands on both teams, and staff from each team covered for each other at times of peak demand.

People's medicines were managed safely where there was a need to support the person to take them. Staff had received training and understood when to report concerns about medicines management. There were arrangements in place to manage emergencies, such as staff not being able to access a person's property. Staff understood about the need to ensure that information about peopl's security was kept safe, for example access codes for key safes.

People received effective care from staff who had the appropriate skills and knowledge to meet their needs. Staff told us they had the training they needed to do their job and were confident in managing situations that we saw and discussed. They had rapid access to equipment or services to support them to care for people effectively and safely. Staff received support to carry out their role from their line managers, including regular supervision and appraisal.

People were supported with their health and dietary needs, and encouraged to maintain their independence with preparing foods where this was a part of their care plan. People told us the service responded to their wishes; staff were flexible, and made changes in accordance with their goals or requests on a daily basis. People were involved in making choices about their care and their independence was encouraged.

Staff supported people in accordance with the Mental Capacity Act 2005, and people were asked for their consent to care being delivered. Their rights to make decisions for themselves were understood by staff, who sought people's consent before delivering care.

Staff respected people's dignity and privacy, and were professional but caring in their relationships with them. Staff demonstrated a non-judgemental approach to people's lifestyles and in discussions showed empathy and compassion for people in crises.

Communication with people was effective. People were given information about the service in a way they could understand. Staff understood the importance of building a rapport and meaningful relationships with people in crises quickly, and were confident and competent in the interactions that we saw. Records were well maintained, and systems were understood for the appropriate sharing of information between agencies such as GPs and private care agencies.

Summary of findings

Registered managers of both services at this location were supportive of each other and worked well together. Teams were flexible and supportive with a clear understanding of their purpose.

Staff were proud of the work they did, and they received good feedback about their performance. Quality assurance processes had been established and best practice and learning was being used to improve the service outcomes for people. People were actively encouraged to give their views and raise concerns or complaints. The service viewed concerns and complaints as a way of improving the service and any concerns were addressed promptly. People told us they were happy to raise concerns with the service's management.

Summary of findings

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.

Robust recruitment procedures were in place and there were sufficient staff to ensure people's needs could be met. The service was flexible to meet unpredictable demands on both teams.

People were safe because the service had ensured staff understood how to recognise and report concerns about abuse.

Risks to the health, safety or well-being of people who used the service were assessed and reduced where possible. Staff were aware of how to raise concerns about people's well-being to other agencies who would be responsible for managing risks. Policies were in place and well understood to reduce risks to staff working in the community with people potentially in crises.

People's medicines were managed safely, and there were arrangements to manage emergencies, such as staff not being able to access a person's property.

Is the service effective?

Good

The service was effective.

People received effective care from staff who had the appropriate skills and knowledge to meet their needs. Staff received support to carry out their role.

People were supported with their health and dietary needs, and encouraged to maintain their independence with preparing foods.

Staff supported people in accordance with the Mental Capacity Act 2005, and people were asked for their consent to care being delivered.

Is the service caring?

Good

The service was caring.

Staff respected people's dignity and privacy, and were professional but caring in their relationships with them. Staff demonstrated a non-judgemental approach to people's care and in discussions showed empathy and compassion for people in crises.

People were involved in making choices about their care and their independence was encouraged.

People were given information about the service in ways they could understand. Staff understood the importance of building a rapport and meaningful relationships with people.

Is the service responsive?

Good

The service was responsive.

People told us the service responded to their wishes; staff were flexible, and made changes in accordance with their goals or requests on a daily basis.

Summary of findings

People were actively encouraged to give their views and raise concerns or complaints. The service viewed concerns and complaints as a way of improving the service and any concerns were addressed promptly. People told us they were happy to raise concerns with the service's management.

Is the service well-led?

Good

The service was being well led.

Registered managers of both services at this location were supportive of each other and worked well together. Teams were flexible and supportive with a clear understanding of their purpose.

Staff were proud of the work they did and positive about the people they were supporting. They received good feedback about their performance.

Quality assurance processes had been established and best practice and learning was being used to improve the care being provided for people.

Records were well maintained.

St Edmunds

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 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 8 and 9 February 2016 and was announced. The managers were given 48 hours notice because the location provides domiciliary care services, and we needed to ensure that the manager and other staff would be available to spend time with us. The inspection team consisted of two adult social care inspectors on the first day and one on the second, which involved visits to people's homes.

Before the inspection, we asked the provider to complete 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 reviewed the completed PIR and checked the information that we held about the service and the service provider. On the inspection visits we spoke with both the registered managers and the senior manager for both services within the Trust. We also held discussions with the Trust about other services operated by the Trust that provided adult social care that were not registered. The Trust told us they were making an application as a result to register another service.

We spoke on the telephone with four people or their relatives who received a service from the IHSS team and visited three people in their own homes with their permission. We spoke with three people or their relatives using the CRT service by telephone. We discussed with them the care that they received. On the home visits we saw how people were supported, talked with people about the service and looked at the records that were kept in their homes. We spoke with seven members of staff about working for the teams, the care they gave people and the training and support they received. We participated in a team meeting and two staff handovers. We saw staff taking referrals for the CRT and discussed with them how the systems worked.

We reviewed a range of records about people's care and how the teams were managed. These included looking at care records for four people held at St Edmunds, and three files in people's homes; three care staff files and other records relating to the management of the service including training records, policies and procedures, staff rotas, records of audits, and quality assurance systems.

Good

Is the service safe?

Our findings

Systems were in place to help protect people from the risk of abuse. Staff from both teams knew how to recognise signs of possible abuse, and there was information available for staff about how to raise safeguarding concerns. Staff told us they had received training in safeguarding procedures for both adults and children and knew where to access information if they needed it. This was because although the service did not provide care to children staff might have an involvement with children in a home setting while carrying out their role. One member of staff said, "If I see anything detrimental to the person's wellbeing I will report to my manager or the emergency duty service (EDS) if out of hours." Another said, "I will protect people from harm, I would get as much information as I could and speak to my manager." Staff were knowledgeable about the Trusts whistleblowing policy and felt happy that they could go to a manager to raise issues, confident they would be listened to. No safeguarding concerns had been raised about the service.

On occasions staff carried out small amounts of emergency shopping for people. The systems in use for recording these transactions did not in every instance include the person's signature to confirm the amounts of cash involved or returned to the person. The registered manager took immediate steps to ensure staff were reminded of the need for this.

Clear protocols were in place and understood by staff about what to do if they could not gain access to a person's property on a visit. Staff wore identify badges and people told us they knew roughly when staff were coming to them, although they did not have a specific time. We saw staff kept information about people safely, for example access codes to keysafes.

Risks to people receiving a service and staff providing this were assessed and managed either through the team or through referral to other agencies. Staff from the CRT carried out immediate risk assessments at the point of referral and on the first visit to the person. These were recorded on a form in the crises response pack, and would be cross referenced with information held on the Trusts computer systems from previous involvements with the person. CRT staff told us they would take action to mitigate risks at the point of contact with the person wherever possible but would usually refer to other agencies to manage any risks. For example staff would refer any wounds identified to the district nursing team for management and assessment. We saw a computer record of a person's recent care. This included information from a multidisciplinary team about a risk to the person's well-being. Following short term involvement of the CRT service this risk was raised back to the specialist services within the Trust for their action and longer term management.

People receiving the service might also be asked to reduce assessed risks themselves, for example by restraining pets or ceasing smoking while Trust staff were at their home. First visits to people in crises about to receive a service were made by two staff so that a fuller risk assessment could be completed in a safe environment. Risks and any controls used were then recorded on the Trust IT systems so that if further visits were made staff would be aware of any concerns and what actions needed to be taken to reduce them. Staff had access to out of hours contacts in case of concerns about how risks should be managed or referred, and this included access to security personnel within the Trust. The registered manager confirmed that services had occasionally in the past been withdrawn if risks to staff could not be managed.

For the IHSS staff, risk assessments and risk reduction plans were available on the Trusts computerised record system. We saw a record for one person which included scanned information from the speech and language service about the person's risk of choking, and what actions the person needed to take to reduce the risks. Following involvement of the team the speech and language service was contacted to re-escalate concerns about the person's well-being. The records showed the speech and language team had visited the person and reviewed their needs as a result. Staff had the ability to request equipment from the Trust zone teams without delay, for example to relieve pressure or support people with their independent mobility.

Staff felt that they were well protected as lone or community workers and had a robust system in place to protect each other whilst out on visits. They described that staff also kept in contact with each other by phone and used a recognised code word if they felt they were in danger. A new system was being provided which would enable staff at the location office to contact staff. This would also support staff to raise alarms without the person

Good

Is the service safe?

supported being aware. Staff contacted their base to log in and out of each person's home so management were aware at any time where they were. Following any incidents staff had access to support and longer term counselling if they needed this.

There were enough staff available to meet the changing needs of the services. For the CRT service in particular staffing needed to be flexible as demand was ever changing and unknown in advance. Staff felt that there were enough staff on duty to meet the needs of the people and said that the teams always supported each other when under pressure and during times of staff sickness. We saw that if there was excess demand on the CRT service the re-ablement team/IHSS would step in to support and provide cover if they had capacity and vice versa. The services had core safe minimum staffing levels. Staff felt that they were able to spend enough time with people as they were not given any time constraints. One staff member said "I take as long as necessary. If I'm running late other team members will step in to help out".

If referrals were in excess of the capacity of the IHSS team then we were told they would not accept the referral but put the person on a waiting list for when there was capacity in place. We heard that this might for example mean that a person remained on an intermediate care placement for a few days longer to ensure that they could be discharged home safely. Staffing levels could be increased at times of significant demand. Where any agency or bank staff would be used they would need to be familiar with the service and would be working with a regular member of the team to provide back up support or to support people who needed two staff.

At times staff from either service might be needed to administer medicines for people in their homes. The service did not hold any medicines in stock. Staff told us that they would only administer medicines if they were asked to do so on the referral form. They told us they would alert the local authority zone staff to request a GP review if there were any issues or lack of clarity over the person's medicines. We saw that a GP had recently been contacted to take responsibility for one person's medicines. The services had medicines management policies in place, and pharmacist staff from the Trust had visited people in their homes and seen how staff administered medicines to them to ensure the systems were safe. People were encouraged to manage their own medicines if they had capacity to do so, for example taking insulin under supervision. When we visited people in their homes we saw staff recorded any medicines given on medicine administration records or MAR. For one person it was identified that the person might not have been managing their medicines successfully independently, so the concern was passed on to the appropriate team for additional support and review. Staff had received training in safe medicines administration from the medicines management team from within the Trust.

Systems were in place to identify and manage any risks concerning the safe recruitment of staff. Robust recruitment checks were completed to ensure care workers were safe to support people. We looked at three staff files. All staff files seen contained evidence to demonstrate a full recruitment process had been followed, including disclosure and barring service (police) checks.

Systems were in place to ensure staff protected people from the risks of cross infection. Advice was sought from infection control teams if specific risks were identified. Staff wore aprons and gloves when supporting people and these were carried in their cars along with first aid kits. Staff had a good awareness of universal infection control practices.

Good

Is the service effective?

Our findings

Staff received the training they needed to carry out their role. People told us they were supported by staff who had the knowledge and skills required to meet their needs. Staff files recorded training undertaken and individual's core training was identified on a central training recording system. This sent alerts to the registered managers when people needed refresher training in core areas such as first aid or infection control. Staff received training and support where needed to maintain their professional registration.

Staff were knowledgeable about people's care needs and had the skills and knowledge to support them. They had access to the Trust's eLearning systems and could enrol on any courses that interested them. They were also offered access and encouragement to complete NVQ Level 3.

One staff member said "If you mention a course, (name of registered manager) will get you a leaflet or information". One person receiving a service said of the staff "Very pleasant, positive, respectful, efficient and work well as a team."

We were told by staff that all new staff members were supported by a mentor. Staff had a period of supernumerary time, the length of which was tailored to the individual depending on their experience and confidence. Staff said that this was really valuable in preparing them for their role. The staff from both services felt that they were well supported by their respective managers and by other team members.

Staff received regular supervision every three months. During supervision, staff had the opportunity to sit down with their line manager to talk about their job role and discuss any issues and further training wants and needs. Staff could also ask for supervision more frequently if needed, and there were annual appraisals. Regular staff meetings took place. Staff told us they felt that these were open and honest and they were able to discuss anything they wanted.

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.

We checked whether the service was working within the principles of the MCA. Staff understood about respecting people's capacity to make decisions for themselves, and we saw they asked people for their consent to care before tasks were carried out. We were told that if there were doubts about people's capacity then referrals would be made to other agencies to carry out assessments in people's 'best interests'. Staff confirmed that they understood people had the right to refuse care and staff had received training in principles around consent.

Both services might at times be involved in ensuring people had food and drinks available to support their health. Some people's food intake was monitored as they were at risk of poor nutrition or hydration, and other people were being encouraged to make their own meals. The care files in their homes contained information on food they had eaten and this was reviewed to ensure they had a balanced diet. Records and care seen on home visits showed staff left people at the end of their visit with access to drinks or snacks if they wished.

We saw evidence that people were supported to have access to the community healthcare services they needed. Staff from both teams were confident in contacting healthcare staff to request additional support for people. One person we visited was also receiving support from community healthcare staff who visited while we were at the person's home. The healthcare worker told us teams worked well together to meet people's needs. The rehabilitation/IHSS was a therapy led team, which meant an occupational therapist (OT) led and directed the care and support staff. They also supported staff on visits, which meant specialist advice was available immediately for example with regard to equipment or suggestions for improving the person's independence.

Good

Is the service caring?

Our findings

People told us the staff who supported them were caring. They told us "They are all very good – I can't fault them" and "I have no complaints at all about the girls…they are all wonderful".

As the CRT service was a crisis response service, often the staff had very little information about the person prior to their visit. Staff from the CRT described how important it was for them to establish a rapport with the person to gain their trust at an early stage. They told us they used good communication and interpersonal skills, such as making eye contact, speaking to the person in a pleasant way, smiling and displaying confidence and knowledge in the care that they were giving to achieve this. One staff member described how they would sit down and have a chat with the person, listening to them and talking about their family and interests to put the person at ease before attempting care.

Staff respected people's individual communication needs. Each person referred to the CRT or IHSS service was given an information pack which was kept in their home. Staff told us "We will go through this with them when we first see them and assist them with any sensory issues by using tools such as picture boards". Staff were aware of procedures to make referrals to sensory teams to allow people to be independent with their communication.

Staff were aware of issues of confidentiality and confirmed that this was maintained by locking away all information regarding a person's care. The only documentation left at the person's home was their individual CRT or IHSS/ reablement pack which was the person's responsibility to maintain. Staff told us they did not share information about people they cared for unless they had concerns about people's care and welfare. They were non-judgemental when discussing people's circumstances or situations resulting in them needing support.

Staff understood the importance of promoting independence and this was reinforced in peoples care plans. People we saw being supported by the reablement/ IHSS in their own homes were clear about the aims and goals of the services they received which had been discussed and agreed with them. In instances we saw this included goals such as climbing stairs in their house, recovering skills lost during a stay in hospital or re-gaining confidence after a fall.

We sat in on a team meeting for the reablement/IHSS service and attended a handover meeting for the CRT team. In both meetings we heard people's needs were discussed in a caring, compassionate and supportive way. Suggestions were put forward to improve their care in ways that showed staff had a real interest in people's on-going well-being. Staff expressed empathy and support for people in crises.

We shadowed a staff member on three home visits. We saw they were respectful of people's privacy and dignity. People's choices about their care were respected, including locations where care was delivered.

Good

Is the service responsive?

Our findings

People's preferences were taken into consideration and staff listened and acted on people's choice and wishes about their care. One staff member described it as "Active participation – giving them choices, asking what they want to do". People told us that the service met their needs and was helping them stay in their homes. One relative told us "They have been doing a really good job with (person's name). They are working with us to keep (person's name) as well as possible under the circumstances. I am not sure how we would have coped without them".

Care plans that we saw both in the office and in people's homes reflected people's wishes on the care they needed. People receiving the IHSS support had goals set with them at the point of referral and discharge from hospital. The registered manager of the IHSS service told us that they were working to allow people to set these goals with the IHSS team in their own homes rather than them being set by the hospital team at the point of discharge. This was because they felt people's goals changed and became more realistic once they were back in their home setting, and areas of difficulty were more easily identified with tasks of daily living. Goals were regularly reviewed at team meetings. These ensured that people's progress was monitored, and all staff were aware of any changes or new areas of focus. As people improved the service was gradually reduced as goals were met or new long term providers of care were identified.

For the CRT team the care plans were briefer, aimed at identifying short term goals for support, any on-going referral needs and any specific risks to people or others. Plans were based on the information received at point of referral, discussions with the person themselves and assessments made on the first visit. Once the service was completed the care plan was transferred onto the Trust IT system for future reference and to allow access to other staff within the Trust.

In people's homes we saw that staff checked the care plans when they arrived to make sure there had not been any changes as well as asking people if there had been any changes. People were asked what they would like the staff member to help them with on their goal sheet. Where needed body maps were included in people's care plans to record any concerns over poor skin or potential pressure ulcer damage. Phone alerts could be sent to staff to alert them to any changes to routines or people's condition.

People were not generally supported by either service to take part in activities in the community. However, staff were very aware of the risks of social isolation and risks to people's health as a result. One person had received short term support to continue to attend a memory clinic and other social interactions. Another person had an identified goal on leaving hospital which was to regain the ability to go back to a local club. The person was referred by the service to the Lifestyles team run by the Trust and was supported to attend the referred exercise programme run by the Trust. This had increased their ability to be involved with their local community.

People were actively encouraged to give their views and raise concerns or complaints about the service. Information was available about how to contact the service and how to raise any concerns in the front of people's care folders in their homes. People told us they would raise any concerns if they needed to or were worried about any aspect of their care. They were aware of the numbers to use. Information was also included in the patient held folder about services such as Patient liaison services who could support them in raising a concern. Some people however were not clear about which agency involved with their care was providing which service as some people had visits from several staff teams supporting them. Registered managers confirmed that any complaints made would be viewed as learning opportunities for the service. Effective systems were in place to ensure that any complaints were investigated thoroughly and issues escalated within the Trust.

Good

Is the service well-led?

Our findings

Both staff and the registered managers were proud of the services they worked for. Teams worked well together to support each other. There was a shared ethos of confidence and an understanding of the importance of good flexible needs led patient centred care. They told us "I really love it", "This is an excellent team" and "I really feel I have all the team support I need". Staff told us that the registered managers placed a lot of trust in their teams. One said the registered manager "led by example" and supported them to improve their knowledge and practice.

Both registered managers had an open door policy and were involved and accessible at the service. They provided cover for each other for annual leave to ensure one was always available for staff to discuss any concerns with. Both registered managers had a clear understanding of what was happening in their teams at any given time during the day, and of any pressures and risks. People told us they were very supportive. One said "I could call the manager at any time. They are a really good leader". There was a positive atmosphere and the meetings we attended were helpful in identifying actions that needed to be taken and people accountable for them. Staff told us the registered managers took on board any suggestions to improve and develop the service and they all had input during team meetings on how to improve care. There were clear staffing structures and staff understood delegated levels of decision making.

Systems for the quality monitoring of staff practices while working with people were in place. Staff told us that their manager carried out spot checks and "observes us and checks that we are following policy and procedures". Staff had received copies of the trusts 'Code of Conduct' and policies for safe working.

Audit systems were in place to monitor the quality of the services people received. These included questionnaires sent out to people at the end of the service for their comments. These were then analysed to identify any trends or concerns. These were also used to help with staff morale and to develop their skills. One staff member told us they knew they were doing a good job because "job satisfaction and feedback lets us know that we are doing well. (name of registered manager) will always tell us and show us feedback forms". Feedback seen had been overwhelmingly positive. Other systems including auditing of welcome packs, use of body maps and training.

Information on good practice was used to develop the service. One registered manager told us they had used the National Audit on Intermediate Care as a framework for auditing the service's practice and had also assessed themselves using information from the Care Quality Commission. Quality meetings were held along with regular team meetings to share good practice and identify areas that could be improved.

Records were well maintained and staff understood principles of good record keeping and confidentially. The Trust had systems in place for good governance of records, including safe disposal and storage of records.