North East London NHS Foundation Trust

Community Care Advice Centre

Inspection report

Aldborough Road North
Ilford
IG2 7SR

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service caring?	**Inspected but not rated**
Is the service responsive?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Community Care Advice Centre is a reablement service providing personal care to people seeking to regain their independence following accident or injury. At the time of the inspection 30 people were using the service though they can support up to 60 people.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
People and relatives had mixed views about the window in which call times were provided. Some would have preferred more precise times for visits. The registered manager told us this occurred so people with more complex needs could be prioritised. The service had robust recruitment processes. People were safeguarded from abuse as staff were trained to spot the signs of abuse and knew what to do should they suspect abuse. Risks to people were assessed and monitored and any pertinent information shared with relevant teams who worked with people. There were robust infection control practices in place. The service had adequate supplies of Personal Protective Equipment (PPE) and staff had been trained how to use PPE. The service learned lessons when things went wrong and learning was shared with staff appropriately.

People's needs were assessed before they began using the service to ensure they could be met by the service. Staff were inducted into the service, so they knew what to do when they began working. Staff received ongoing training to ensure their competency was up to date. People received effective care as the service worked alongside other teams, appropriately sharing information about people to ensure they received good quality care. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Staff sought people's consent and were trained in the Mental Capacity Act.

People told us staff were caring. Staff were trained in equality and diversity and understood the need for cultural sensitivity when working in people's homes. People s privacy was respected and their independence promoted.

People's care was planned and their needs recorded. Staff understood and provided person-centred care, placing people at the heart of their care. The service met people's communication needs, offering support in different languages where required. People knew how to make complaints and the service responded to these appropriately.

People and staff spoke positively about the provider and service management. The provider was aware of duty of candour and their responsibilities when things went wrong. The registered manager and staff

understood their responsibilities and roles. People and staff were able to be involved with the provider and help develop how the service was delivered. There were effective quality assurance processes in place, though due to the pandemic some of these had been suspended so the provider could reallocate staff resources to combat effects of the pandemic. The service worked well with other teams and sought to ensure people received joined up care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on 23 May 2019 and this is the first inspection.

Why we inspected
The inspection was prompted due to the service not having been inspected before.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service effective?

Inspected but not rated

We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service caring?

Inspected but not rated

We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service responsive?

Inspected but not rated

We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Community Care Advice Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act.

Inspection team
The inspection was carried out by one inspector.

Service and service type
This service is a reablement service. It provides personal care to people living in their own houses and flats and specialist housing.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 17 December 2020 and ended on 09 January 2020. We visited the office location on 17 December 2020.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority and professionals who work with the service
The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with two people who used the service and two relatives about their experience of the care provided. We spoke with three members of staff including the registered manager and two support workers.

We reviewed a range of records. This included three people's care records and a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at three staff files in relation to recruitment, training data and quality assurance records.

Inspected but not rated

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has not been rated as we have only looked at the part of the key question.

Staffing and recruitment

● People and relatives had mixed views about call times. One person said, "It's when they come at different times which is frustrating." A relative said, "The only thing I found odd, they said they can't give me a time [when they will visit.]"

● The service offered a four-hour window in which they stated staff would attend. People using the service were informed about this verbally when they began using the service. The registered manager told us the window was in place to provide flexibility to staff to meet the fluctuating demands on service capacity. They also said double handed calls, where two staff needed to attend, were prioritised for earlier in the day given the potential complexity.

● People and relatives told us there were often different carers which they had mixed views on. One person said, "Quite a lot of different staff - this morning [member of staff} is lovely and helped me have my shower and wash my hair. Some are much more helpful than others". A relative said, "We have different carers, but they tend to be the same [who return] so you build a rapport." The registered manager stated the service's flexibility to meet demands meant people were not always seen by the same members of staff though this was something the service aimed to provide where possible.

● The service had robust recruitment procedures. Employees' employment history, references and suitability to work with vulnerable people were checked before they started employment. Service user representation was also used at interview. This meant people were kept safe as staff were recruited with people's safety in mind and people's input was sought in the employment process.

Systems and processes to safeguard people from the risk of abuse

● People and relatives at the service told us they felt safe. One person said, "I did actually [feel safe]."

● There were systems in place to ensure people were safeguarded against abuse. The service had not needed to raise any safeguarding alerts with local authorities about people being at risk of abuse, but they had systems in place to ensure staff could raise these issues with the provider, who in turn would seek to safeguard people.

● Staff had received training in safeguarding and could recognise different types of abuse. One staff member said, "I would say if I see anything or have concerns, I would report it. I make sure my patients are safe."

Assessing risk, safety monitoring and management

● Risks to people were monitored and mitigated. This service was a reablement service often providing care immediately upon discharge from hospital. We saw referrals and hospital discharge summaries highlighting relevant risks to people, so service staff could fulfill their role whilst ensuring people were kept safe.

● The provider is a National Health Service foundation trust and as such employed a variety of different health and social care professionals and teams to work with people. Different teams worked in a joined-up

manner to ensure people's needs were met. This included intensive rehabilitation teams and district nurses.
● The provider's systems captured information about risks to people which staff could access and share should they require it. This included information about people's medicines and health conditions. For example, we saw notes where it was felt a person was at risk of pressure sores. Carers were aware of this information and were subsequently concerned and shared the information with district nurses who attended the person within 24 hours. This meant people's risks were monitored and mitigated against through good systems and joined up working.

Preventing and controlling infection
● People and relatives told us people always wore personal protective equipment (PPE). One person said, "Yes they do [wear PPE]." A relative said, "When I saw them, they wore gloves and aprons."
● Staff understood the importance of infection control and the need to wear PPE. Staff comments included, "We wear our PPE, we have aprons, gloves, masks, visors and shoe covers. We make sure we dispose them and not reuse them." Staff had received training in the use of PPE and infection control.
● The service had an adequate supply of PPE and had updated their infection control policies and training due to the COVID-19 pandemic. Similarly, there were enhanced risk assessments for staff which covered potential risk factors such as pre-existing health conditions and race.

Learning lessons when things go wrong
● Lessons were learned when things went wrong. The service recorded all incidents and accidents, and these were analysed by the registered manager and shared with more senior directors, who have oversight for the service as it is part of an integrated care directorate, as well as the provider's health and safety and safeguarding teams (the provider is an NHS foundation trust). This included if there were allegations of abuse. Any relevant learning was shared with the staff team so improvements could be made to how care was delivered.

Inspected but not rated

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were assessed before they began using the service. The service recorded people's protected characteristics such as race, religion or sexuality, their health care needs and their social situation in order to ensure they could provide a service to meet those needs. Assessments utilised information complied by a multi-disciplinary team, including occupational therapists and hospital staff, providing information about people's physical needs and on-going treatment requirements.

Staff support: induction, training, skills and experience

● Staff received an induction when they began working at the service. One staff member told us, "It [induction] was the best …I did training beforehand and two weeks of shadowing." Staff received training in order to do their jobs and shadowed experienced workers already completing the role. This meant people would be cared for by staff who knew how to care for them when they started work.

● Staff received ongoing training to complete their roles. One staff member told us, "I have done most of my mandatory training. I have basic life support one to do." The provider had a list of training they required staff to complete, most of which staff were required to repeat at regular intervals. These included topics such the care certificate, safeguarding and manual handling. The care certificate is an agreed and recognised qualification in standards that define the knowledge, skills and behaviours expected in the health and social care.

● Staff were supervised in their role. One staff member said, "We get it [supervision] monthly. Yes, I do feel supported." Staff were supervised in their roles by members of management who provided direction and support to staff regularly.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Staff worked with other agencies to provide effective care. The provider is an NHS foundation trust and the service worked alongside other teams and departments to ensure people's care needs were met. Staff shared records and databases with these other teams which meant people received more joined up care with staff knowing what others had done. We saw evidence of interaction with occupational therapists and district nurses.

● Staff referred people to health care professionals when necessary. People who were new to service were discharged from hospital and on occasion required more support than the service could offer. We saw one example where a patient was discharged from hospital into the service and staff referred the person to local district nurses following the first care visit. Notes on the provider's system indicated the nurses saw the person within 24 hours of referral. This meant the service supported people to access healthcare support

they needed.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.
● People's mental capacity to understand decisions was recorded. Assessments of people's needs checked whether they had conditions which may affect their ability to make decisions.
● Staff told us they always sought people's consent. One staff member said, "I would say [seek consent] every time [we work with people]" Staff were trained on the Mental Capacity Act. The service worked with people, relatives and social workers to ensure people's best interests were met. This meant people's consent was sought in line with the law.

Inspected but not rated

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has not been rated as we have only looked at the part of the key question.

Ensuring people are well treated and supported; respecting equality and diversity

- People and relatives told us staff were caring. One person said, "Yes, they were very caring. They were all polite." Another said, "I got to tell you there isn't one thing I could fault them on."
- Staff were sensitive to people's cultural needs. One staff member said, "We do training on equality and diversity. We always respect peoples' cultures, some are Muslim and Christian, and we know how to deal with that. For example, we wear shoes covers when we go into people's houses." Staff received training in equality and diversity and the service had policies which sought to protect people's rights.

Respecting and promoting people's privacy, dignity and independence

- People and relatives told us their privacy and dignity was respected. One person said, "Yes, [staff] do [treat me with respect]." A relative said, "I think so. They shut the door so no one else can see what they're doing [personal care]." One staff member said, "If someone is having personal care, then we'll close the curtains and ensure their privacy is respected."
- People's confidential information was stored on password protected computers or in lockable filing cabinets. There were policies to support data protection and people's confidentiality. There was training on privacy and dignity that all staff completed.
- People's independence was promoted. One staff member said, "My job role when I go to my patients, I don't go there to do things for them, I encourage them to do things themselves; I encourage. I will assist when they have difficulties, but I encourage them to do as much as they can." The service's aim was reablement and helping people towards an increased level of independence. Documentation for people highlighted this aim.

Inspected but not rated

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has not been rated as we have only looked at the part of the key question.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People and relatives told us care was planned and they had a choice in meeting their needs. One person said, "We have that [care plan] on the table and they write down what they've done."
One relative said, "They were full marks, they listened to me and tried to advise me [on choices to make about care]."

● People's care plans were specific and sufficiently detailed. Care plans highlighted people's health concern and why they required the reablement service and stated goals people wanted to achieve. These needs usually focused on a return to maintenance of independence and development of confidence. For example, one care plan stated how long person had been in hospital and how a gradual and guided reduction in support they required would improve confidence and independence.

● Staff understood person-centred care. One staff member said, "The patient is the centre, so the patient will be involved in their care and the care plan is designed around that one person." Care plans included tasks staff were required to carry out each visit. These were presented in a person-centred way often highlighting people's direct requests. For example, one person's goal tasks included, "[Person] would like some support with washing their back, legs and feet, [person] has said that they are able to wash their front down." This meant staff knew what people wanted.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The service met people's communications needs. The provider had access to a variety of resources to support people with differing communication needs. People's communication needs were assessed and recorded. Documentation could be provided in multiple languages to support people where English was spoken as a second language. For example, the service's information leaflet offered the opportunity to provide information in braille and ten other languages.

Improving care quality in response to complaints or concerns

● People and relatives told us they knew how to complain. One person said, "I have not complaints." A relative said, "If I wasn't happy, I would write to the assessor as I have a number, they have been really good and always answers the phone." The provider had a complaints policy and procedure and was able to evidence complaints about the service. Complaints were dealt with either formally or informally, investigated and responded to. This meant the provider sought to ensure people's care was improved

through responding to complaints.

Inspected but not rated

Is the service well-led?

Our findings

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

This is the first inspection for this newly registered service. This key question has not been rated as we have only looked at the part of the key question.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People and staff spoke positively about the leadership of the service. One person said, "They were very approachable." A staff member said, "[Registered manager] is a good manager. They listen if you talk to them. They will try to sort out concerns. They are very helpful and always available."
- People using the service were provided with a service user guide. This document outlined the aims of the service and provided information about how people and relatives could provide feedback on the service to help them improve.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider was aware of their responsibilities with regard to duty of candour. We saw the provider dealt with formal complaints and staff at the service sought to resolve informal complaints. Incidents and accidents were analysed by the registered manager and shared with directors with oversight for the service, as well as the provider's health and safety and safeguarding teams (the provider is an NHS foundation trust).

- The registered manager had not had to notify Care Quality Commissions with respect to events and incidents which affect the service or the people who use it but were aware of their responsibility to do so.
- The registered manager, who was an occupational therapist, was clear about their role and understood what was required of them with respect to oversight of the service and responsibility for quality of care. They managed a team of supervisors who in turn managed support work staff who provided care for people. There were effective management systems in place and all staff had job descriptions for their roles. This meant staff knew what they were supposed to do.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People were able to engage with the service directly by contacting them or by participation in service user involvement schemes and groups. The provider offered opportunities to present or recent recipients of care to engage in patient experience groups. This extended to opportunities representing service users at interviews for jobs within the service. This meant people had the opportunity to help shape and improve services by their involvement.
- Staff attended team meetings. The regularity of meetings had been affected by the COVID-19 pandemic but we saw minutes from previous meetings where topics of discussion included incidents and accidents

and patient care and management concerns. One staff member told us, "I would say we need to have meetings a bit more but it's understandable given the pandemic. People voice their concerns and talk about things."

● Staff supervision also provided staff with an opportunity to engage with the service and to receive feedback about their work. For example, one supervision record we looked at stated direct service user feedback, "Client was very happy with [staff], said that they looked smart and very professional."

Continuous learning and improving care

● The service sought people's feedback to assist continuous improvement. This occurred through a call to people or via feedback forms left in people's homes. However, the provider had opted to cease calling people for feedback during pandemic lock downs to utilise staff resources differently to respond to the increased burden from pandemic.

● The provider monitored the outcomes of people who used the service. Checks were made on referral sources, reasons for rejected referrals, people needing further care and the outcomes of those who used the service. This, coupled with feedback from people, provided insight into where the service could improve the service and learn from what had happened.

Working in partnership with others

● The service worked with other teams to provide joined up care. One staff member said, "We do all work together. We can contact the district nurse if someone has a redness or sore or if they need equipment, we can contact occupational therapists." The service was managed by an NHS foundation trust. Various teams, including district nurses and occupational therapists shared the same electronic systems and had access to people's care notes.

● The service also worked well with external agencies. We saw evidence of working with other care providers and social workers.