Langstone Society

Langstone Community Care

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?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 14 July 2016 and was announced. We gave the service 48 hours' notice of the inspection because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. At our last inspection on the 25 July 2013 the provider was compliant with the regulations inspected.

Langstone Community Care is registered to provide personal care services to adults in their own homes or supported living environment. People the service supports have a range of needs including physical disability and learning disability. On the day of the inspection, six people were receiving support. There was a registered manager in post. 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.

People were safe within the service. We found that care staff knew how to keep people safe and what actions they should take were they concerned about people's safety. People received their medicines as they were prescribed.

Care staff received appropriate support to ensure they had the skills and knowledge to meet people's needs. The requirements of the Mental Capacity Act (2005) the provider ensured was being adhered to and staff received the appropriate training to ensure people's human rights were protected. We saw people's consent being sought before they were supported.

The provider had support plans in place to meet people's needs which people were involved in. People were supported by staff who were friendly and kind in how they met their needs. People's dignity, privacy and independence was respected.

The support people received was responsive to their needs and people were involved in the decisions that related to how they were supported. The provider had a complaints process in place to enable people to raise any concerns they had as part of a complaints process.

We found that where people lacked capacity that an appropriate mental capacity assessment was not taking place. Where the registered manager carried out spot checks or audits there was no documentation to substantiate this. The provider did not carry out quality audits.

We found that the questionnaire used to gather views were aimed specifically at people rather than a general view of the quality of the service being delivered.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff knew how to keep people safe.

People received their medicines as prescribed.

The provider had appropriate systems in place to reduce risks to how people were supported.

Is the service effective?

Good

The service was effective.

The provider ensured the requirements of the Mental Capacity Act (2005) were being adhered to and staff were able to ensure people's human rights were protected.

People had the appropriate access to health care professionals as required.

Is the service caring?

Good

The service was caring.

Care staff were kind and friendly.

People were able to make decisions on how they were support.

People's privacy, dignity and independence was respected.

Is the service responsive?

Good

The service was responsive.

People were able to share their views and were involved in their support plan.

People were able to raise a complaint if they wanted.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People considered the service to be well led.

There were systems in place to enable people to share their views on the service.

Where people lacked capacity an assessment of their capacity was not taking place.

We were told that checks and audits on the service were taking place but we saw no evidence of these by the provider or registered manager.

Langstone Community Care

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Our inspection took place on 14 July 2016 and was announced. We gave the service 48 hours' notice of the inspection because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The inspection was carried out by one inspector.

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. Due to technical problems a PIR was not available and we took this into account when we inspected the service and made the judgements in this report. We reviewed information we held about the service. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law.

We requested information about the service from the Local Authority (LA). They have responsibility for funding and monitoring the quality of the service. We received information from them which we used as part of the inspection of this service.

We visited the provider's main office location. We spoke with two people (as the other people using the service were unable to share their views), two relatives, two members of the care staff and the registered manager. We reviewed two care records for people that used the service, the records for three members of the care staff and records related to the management and quality of the service.

Good

Is the service safe?

Our findings

A person said, "I do feel safe". A relative said, "[Person's name] is absolutely safe". Care staff we spoke with were able to explain the actions they would take if they had concerns someone was at risk of harm. We found that care staff received the appropriate training to keep people safe. A member of the care staff said, "Yes I had safeguarding training and would report any concerns to the manager".

The provider had systems in place to manage risks. We found that risk assessments were completed to cover a range of support areas for example, the environment where people lived, administering medicines and where people were at risk of choking. Where people went out into the community, this was also risk assessed to ensure that the right actions had been put in place to reduce any risks. Care staff we spoke with explained that they were able to access these documents whenever needed and care staff had to sign to show they had read and understood the actions required to reduce or manage any identified risks. Care staff showed a good understanding of the risks to people. We found that where people were assessed as having challenging behaviour that the risk assessments showed that two care staff would support them when they were out of the home.

A relative said, "I do feel there is enough staff". A care staff member said, "When we take people out shopping we always have two staff". We found that staffing levels were determined by the local authority who commissioned the service. Where people went out of their home staffing levels were increased to ensure people's safety as determined by their support needs. We saw that the support people received was delivered to them when they wanted on a timely basis and care staff were consistently visible with people where they lived.

The care staff we spoke with told us that they completed a Disclosure and Barring Service (DBS) check as part of the recruitment process before being appointed to their job. These checks were carried out as part of a legal requirement to ensure care staff were able to work with people and any potential risk of harm could be reduced. We found that the provider had a recruitment process in place to ensure all new recruits had the appropriate skills, knowledge and experience to be appointed. We found that references were being sought to check the character of potential new recruits and proof of their identification was part of the recruitment process.

A person said, "I can get tablets when I feel pain". A relative said, "Medicines seem okay I haven't had any concerns. When [person's name] stays over at our home staff always make sure we have the right amount of tablets to give her". We found where people were supported with medicines 'as and when required' that care staff had access to appropriate guidance to ensure people received these medicines consistently. Care staff we spoke with told us they were not able to support people with their medicines unless they had completed medicine training. We found that medicines training was part of the training staff had to complete once they were appointed into their job role. Where people were supported with their medicines a Medicines Administration Record (MAR) was completed by care staff to show what medicines people had been supported with. Care staff confirmed that the MAR was being used for identifying when medicines had been administered.

Good

Is the service effective?

Our findings

Relatives we spoke with told us that care staff did have the skills and knowledge to support people. A relative said, "Staff do know how to support [person's name]". Care staff we spoke with told us they were able to get support when needed. One member of the care staff said, "I do feel supported in my job, my manager is very supportive".

We found that care staff received supervision sessions and were able to attend staff meetings to gain the advice and guidance needed in their job. Supervision is a formal meeting where staff and their manager are able to discuss work concerns. Care staff were able to attend appraisals where they were able to discuss their development and training requirements. Care staff we spoke with confirmed this.

We saw that care staff were able to access a range of training to ensure they had the skills and knowledge to support people. Care staff were also able to access training specific to people's support needs. For example, training in epilepsy, swallowing awareness, diabetes and challenging behaviour. A member of the care staff said, "I have done training in choking". We found that the provider had an induction process that all newly appointed care staff had to go through. A care staff member told us, "I did go through an induction which involved me shadowing more experienced staff". We found that the care certificate had not been used due to no recruitment having taken place for some time. The registered manager was aware of the care certificate and it purpose and intended to implement it for newly recruited staff. The Care Certificate is a national common set of care induction standards in the care sector, which all newly appointed staff are required to go through as part of their induction.

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.

We found that care staff we spoke with were knowledgeable about the MCA and Deprivation of Liberty Safeguards. They told us they had completed training and while no one within the service had their human rights restricted, best interest meetings were taking place where people lacked capacity.

We found that where people were able to give verbal consent this was taking place. A person said, "Staff always get my consent before they help me". A relative we spoke with said, "He [person] is able to give consent". Where people were unable to verbalise their wishes, care staff were able to describe to us how through gestures, their knowledge of people and relatives input they were able to know whether someone was giving consent.

A person said, "I decide what I eat and drink". Care staff we spoke with told us that people decided what they had to eat and drink. We found that care staff did encourage and monitor the types of food and drink people

had. Where people were at risk of choking or were diabetic care staff were involved in encouraging and directing people to the meals and drinks that would be more appropriate. Where a dietician or Speech and Language Therapist (SALT) was required to give advice to people or support staff with guidance this was taking place.

We saw that people's health care was an important part of the support they received from care staff. Health action plans and hospital passports were key documentation used to note people's health care needs so health care professionals would be able to have access to people's vital health care information when needed. We found that people's wellbeing was being checked to ensure they were healthy. This was being noted in a health check book which also showed people's health appointments. A member of the care staff told us that the chiropodist had visited the day of our inspection. Care staff told us they supported people to get to appointments where required and would arrange for health care professionals like a doctor to visit people when they were not well. We saw that people had access to a dentist, doctor, optician and other health care professionals as needed and this was all being noted in their health check books.

Good

Is the service caring?

Our findings

A person said, "I am happy living here, the staff are nice and friendly". A relative said, "The staff are friendly, they always give her [person] hugs and they all have a laugh and get on". Care staff we spoke with said, "The people are so friendly and nice and we all build up a relationship". We found from our visit to two people's home that the environment was warm and friendly and both the care staff and people respected each other. Care staff spoke to people respectfully and people were able to share their views and tell the care staff what they wanted.

A person said, "Staff do listen to me". We found from our observations that people decided what they did and how they lived their lives. Care staff were seen communicating by way of encouragement or advising people. Care staff told us that they listened to what people wanted and if they wanted to go out they could do so. It was clear from what we saw that the ultimate decision makers were the people being supported. A person said, "I am going shopping in a while and [staff member's name] is coming with me as I am unable to go out on my own". A relative said, "Staff do listen and then act accordingly".

We found that people had access to an advocacy service when required. This service was being used where people who lacked capacity needed someone to act in their best interest. We saw that where people were unable to make a decision as to how health care treatment was to be given or were unable to understand certain information an advocate was used.

A person said, "Staff do respect my dignity, privacy and independence". A relative said, "[Person's name] is able to do as much as he can for himself". Care staff we spoke with were able to show an understanding of the importance to respect people's privacy, dignity and independence. A member of the care staff said, "When I am supporting with personal care I always make sure the door is shut and [person's name] is covered over". We saw that people were able to live their lives independently and their privacy and dignity was being respected. Care staff encouraged people to do as much as they could to promote their independence and daily living skills. For example, people would be encouraged to make their own drinks rather than rely on care staff.

We saw that people were able to communicate their views to care staff. care staff used a ranged of methods to enable people to communicate. We saw care staff using hand gestures and sitting down next to people face to face as a way of supporting people to say what they want or just communicate their views. We found that documentations were in more than one format so people were able to understand them and as a result be able to share their views with a good understanding of what they had seen.

Good

Is the service responsive?

Our findings

A person we spoke with and relatives told us they were involved in the assessment and support planning process. A relative said, "I was involved in the assessment and care plan process and I attend a review annually". Care staff we spoke with told us people's support plans were available for them to access when required and reviews did take place. We found that while there was no assessment documentation available on people's files there were support plans, which were available in picture formats to aid people's understanding, centred around the person's support needs and for care staff to refer to in people's homes. Review documentation was also in place. We saw that people and relatives were involved in the review process and the outcome from these meetings was noted for future reference. The registered manager told us that pre-admission assessments had been archived, but arrangements would be made to put these records back on people's care files.

We found that care staff were involved in ensuring people had a full program of social events of their choice to take part in. People we spoke with confirmed this. One person said, "I am going out later with [staff name]". People were able to share their views and make decisions as to how they were supported by care staff. A person said, "Staff do listen to me". We observed care staff putting people first and ensuring the choices and decisions made were by the people they supported.

We found that people's equality and diversity needs were being considered as part of how they were supported. Care staff attended training in equality and diversity so they had the understanding and knowledge to be able to ensure people were supported in a way that promoted their diversity as an individual. We found in people's support plans that where they were religious or had a particular requirement that this was noted so care staff would be aware when supporting them. A member of the care staff said, "Equality and diversity is part of how people are supported. For example, people are able to go to church if they want".

A person said, "I do know who to complain to, but I have never had to complain". A relative said, "If I had a complaint I would speak with to the manager who is easy going and relaxed. I have never had to complain". The provider had a complaints process in place. We found that the complaints process was available in picture format to support people to be able to make a complaint if they needed to. Care staff we spoke with were able to explain the process they would follow if someone had a complaint. This showed they had a good understanding of how to deal with a complaint. We found that there had been no complaints received by the service.

Requires Improvement

Is the service well-led?

Our findings

We found that mental capacity assessments were not taking place where people lacked capacity. We discussed this with the registered manager who confirmed these assessments would be introduced immediately.

A member of the care said, "I do have my medicines competency checked". Care staff we spoke with confirmed the registered manager checked their medicines competency regularly. The registered manager confirmed this was done, but we saw no evidence of these checks. The registered manager told us that the checks were observational and no documentation was being completed. They confirmed that documentation would be implemented immediately.

A care staff member said, "I do see the manager doing spot checks". The registered manager told us that they carried out spot checks and audits but did not keep any documentation to be able to show any evidence of their findings. The registered manager confirmed they would introduce documentation in order to show their findings from spot checks on the service, the environment where people lived and audits on medication. The provider did not carry out quality audits on the service to ensure the quality of the service people received. This would enable the registered manager to be clear on any areas for improvement. The registered manager told us they would discuss this with the provider with a view to implementing a process.

A person, relatives and care staff all told us the service was well led. A relative said, "When I visit [person's name] I am made to feel welcome by staff". A member of the care staff said, "The manager is always around and available when needed". We found that the registered manager was referred to as a supportive person and always available when required. We found that care staff were available to support people whenever they needed and the service supported people in line with their wishes. The culture was one of openness, both in terms of how care staff were supported by the registered manager, but also in how we observed people speaking with care staff.

We saw that people referred to care staff by their first names and this made the environment where people lived warm and homely. People and their relatives all knew who the registered manager was and told us that they could contact him whenever they needed.

The provider had an accident and incident process in place so that where this situation did occur, the right actions would be taken along with the relevant information being noted. Where an incident or accident happened care staff were able to explain how the situation would be logged and what action they would take. The registered manager told us that all accidents and incidents were monitored for trends. We saw that the registered manager had a folder in place to log an accident or incident as part of how trends would be monitored.

We found that the provider had a whistleblowing policy in place. Care staff we spoke with told us they were aware of the policy and knew that the purpose of the policy was to enable them to raise concerns about people's safety or the service, anonymously.

A member of the care staff said, "I am aware of the on call system". We found that the registered manager was part of an on call system outside of normal office hours that staff were able to contact in an emergency.

We found that the registered manager used a questionnaire process to enable relatives to share their views about the service. A person said, "I don't get a questionnaire". A relative said, "I have had a questionnaire to complete". A care staff member said, "I have never had a questionnaire, but [person's name] have had in the past". We found that the questionnaires used were not generic but aimed at each individual person's service received. We discussed this with the registered who told us that the questionnaires they used would be changed to be less directive at people and more general about the service and its quality being received by people. They also confirmed the questionnaires would also be sent out to care staff in the future to gain their views on the service being delivered.

We found that the registered manager knew and understood the requirements for notifying us of all deaths, incidents of concern and safeguarding alerts as is required within the law.

Before the inspection, we asked the provider to complete a provider Information Return (PIR). Due to technical problems a PIR was not available and we took this into account when we inspected the service and made the judgements in this report.