St. Vincent's And St. George's Association

Phoenix

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 19, 20 and 21 January 2016 and was announced. Phoenix provides personal care to older and younger people with a learning disability, sensory or physical disability, dementia or mental health needs living in their own homes in Gloucestershire. Some people lived in private homes on their own or with family and other people lived in shared housing. Phoenix was providing personal care to seven people at the time of our inspection.

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 and associated Regulations about how the service is run.

People received individualised care which reflected their personal preferences, aspirations and routines important to them. Their care records were developed with them to provide staff with clear step by step guidance about how they wished to be supported. Wherever possible people were encouraged to maintain their independence. Any hazards people faced were risk assessed promoting them to continue to do things for themselves as safely as possible. People's changing needs were closely monitored and they were supported to access healthcare professionals to access equipment or treatment to maintain their health and well-being. People's care was reviewed with them and their relatives to make sure it continued to reflect their current needs.

People were supported by a knowledgeable and skilled staff team who had access to a robust training programme. Training specific to people's needs such as end of life training or dementia awareness was provided. Staff were supported in their roles and they were observed carrying out tasks to make sure they had the necessary skills. People said visit times suited them and staff always stayed for the correct length of time. Although there was a large team of staff people knew most of them and were reassured that new staff worked alongside experienced staff before providing their care. People felt safe with the care provided. Staff understood how to recognise abuse and knew about to raise concerns. Staff commented, "Staff recognise professional boundaries; staff are passionate about their work and the people we support."

People's feedback was sought as part of the quality assurance process. This was done in a variety of ways such as surveys, individual and group meetings, reviews of their care and events with the trustees of the

board. Staff felt empowered to voice concerns and said they would be listened to. Improvements to the service had resulted from their feedback. The registered manager was open and accessible, listening and responding to people and staff, dealing with issues as they arose. She recognised the challenges of maintaining a stable staff team who she described as "excelling" in their roles and "going above and beyond". The vision of the provider to provide "excellent" and "person centred care" was embraced by staff. A person told us, "It is a very good service, I like it".

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. People's rights were upheld and they were given information about how to recognise abuse and how to report it. People discussed hazards they may face and worked with staff to develop risk assessments promoting their independence.

People were supported by sufficient staff with the right skills and knowledge to meet their needs. Staff remained with people in an emergency ensuring they stayed safe.

People's medicines were managed safely. Strategies were in place to monitor and check on staff competency when administering people's medicines.

Is the service effective?

Good

The service was effective. People were supported by staff who understood their individual needs and how to make sure these were provided effectively.
Staff had access to a robust training programme to keep their knowledge and skills up to date.

People's consent was sought in line with the recommendations of the Mental Capacity Act 2005. When people were unable to make decisions about their care and support these were done in their best interests.

People were supported to stay healthy and well. Staff had a good understanding of their dietary needs. If needed staff contacted healthcare professionals or emergency services to respond to changes in people's health.

Is the service caring?

Good

The service was caring. People were supported by staff who understood their needs and were passionate about the care and support people received.

People were involved in making decisions about their care and were given information and explanations when they needed

them.

People were treated respectfully, with patience and sensitivity. Their independence was promoted.

Is the service responsive?

Good

The service was responsive. People received care which is individualised and reflected their personal wishes, preferences and routines

People had a variety of ways in which they could raise concerns or complaints, over the telephone, through meetings and at reviews of their care.

Is the service well-led?

Good

The service was well-led. People were actively involved in developing their service, giving feedback through a variety of methods such as surveys, reviews, meetings and service user events.

The registered manager and provider recognised the challenges for the service and put into operation improvements which would sustain the quality of service provided.

Quality assurance systems were effective and strived to enhance the service.

Phoenix

Detailed findings

Background to this inspection

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

The inspection took place on 19, 20 and 21 January 2016 and was announced. The provider was given notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. One inspector and an expert by experience carried out this inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert's area of expertise was learning disability. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we have about the service including notifications. A notification is a report about important events which the service is required to send us by law. We had also received information from a local commissioning team.

As part of this inspection we spoke with six people using the service, a relative, the registered manager, a trustee from the board of directors, two care co-ordinators, nine care staff and the training lead. We reviewed the care records for three people including their medicines records. We also looked at the recruitment for two staff, training records and quality assurance systems including health and safety records. We observed the care and support being provided to two people. We contacted nine health and social care professionals.

Good

Our findings

People's rights were upheld. A person told us, "I have been attacked in the past. I always feel safe once I'm at home". Staff described how they ensured people received safe care and what action they would take if they thought people were at risk of abuse or harm. Staff had completed training in the safeguarding of adults and clearly understood their roles and responsibilities. They had confidence any concerns they raised would be listened to and responded to in a timely fashion. Information about local safeguarding procedures was accessible to people and staff. Easy to read information had been produced for people prompting them about what abuse was and what they should do if they thought this was happening to them. The registered manager discussed incidences when she had shared concerns with the local safeguarding team. She had notified the Care Quality Commission (CQC) about a safeguarding alert. CQC monitors events affecting the welfare, health and safety of people using a service through the notifications sent to us by providers.

People's care and support was discussed with them highlighting any hazards which might impact on their safety or well-being. A positive approach was taken to risk assessment, supporting people to maintain their independence whilst minimising any risks. Where there were concerns about people's mobility, the appropriate equipment had been provided by health care professionals to reduce the risk of them falling. Clear guidance had been provided for staff about the use of equipment such as hoists, slings and standing aids. A pictorial representation of people using their equipment had been provided as an additional prompt. A person commented, "They use my equipment safely, even the new equipment." Staff said they reported any changes in people's needs promptly so that risks could be re-assessed and the necessary action taken to keep people safe.

People's environment had been assessed prior to providing them with care and support. This considered not only risks to the person but also to staff, for example the grounds and entrances or trip risks within their home. Staff explained how they had the contact details of maintenance firms if they identified any problems with people's homes, so they could get repairs done quickly. Staff had been instructed about arrangements for entering people's homes such as where the key was kept or codes to enter buildings. People's care plans prompted staff to make sure people were safe and secure when they left them.

When people had accidents or incidents these were recorded and were monitored by care co-ordinators and the registered manager to make sure the appropriate action had been taken in response. For example, contacting the person's GP to make sure there was no health reason for the accident.

People's safety had been considered should there be an emergency or untoward event. Some people had

individual evacuation plans which described how they would like to be evacuated from their home in an emergency. A disaster plan for local or national emergencies had been put in place which all staff had access to electronically. Staff confirmed there were arrangements for them to contact senior staff out of normal working hours. They said this worked well and they always had a response. There was evidence that senior staff had covered visits where there had been last minute sickness or additional help was needed in an emergency. Staff said they would never leave a person alone if they needed emergency attention and would call for help and wait with them. The registered manager confirmed staff had recently stayed with a person, who had a fall, whilst waiting for the emergency services.
People could be involved in the recruitment and selection of staff, if they wished. One person said they had taken part in interviews for new staff during our inspection. Robust recruitment and selection procedures were in place to make sure the necessary documents and records were obtained prior to appointment. This included a full employment history, verification of why staff left former employment with adults or children and a satisfactory Disclosure and Barring Service check (DBS). A DBS check lists spent and unspent convictions, cautions, reprimands, final warnings plus any additional information held locally by police forces that is reasonably considered relevant to the post applied for.

People's requirements about the level of staff support they needed had been monitored closely. Staff discussed with us when people needed the support of two staff, for example for moving and positioning or when going out into their local community. Staff confirmed staffing levels were maintained and agency staff had rarely been used. The registered manager commended the staff team on their willingness to help cover sickness and annual leave, "going above and beyond". A new electronic rota system had been put in place which required staff to log in and out by telephone when visiting people. This not only tracked the timings and length of visits but also highlighted to staff in the office if there was a problem with staff delays. They said they could then contact people to let them know if their visits were going to be delayed for any reason. People confirmed the length of their visits and timings were as agreed in their care records. They said staff always stayed for the correct length of time and there was some flexibility if they needed to change times of visits or increase the length for any reason. One person commented, "I only have to pick up the phone to [manager] or one of the care co-ordinators if something goes wrong."

People said they were supported by a large number of staff. The care co-ordinators tried to match people with staff and provide consistency and continuity in their care and support. Some people had a core team. Staff told us, "One person I support is autistic so only four of us work with her, that way she feels ok." People recognised when staff left they had to get used to new staff but they told us new staff always worked or shadowed experienced staff until they were confident to work alone. One person had requested not to have a particular member of staff supporting them and this had been respected. People had been given copies of a rota identifying which staff to expect for each visit. Staff also prompted people as they left about which staff would be visiting them next.

People's medicines were managed safely and wherever possible people were supported to take care of their own medicines. Their care plans and risk assessments detailed what people could do for themselves and the role staff needed to play, such as reminding people to take their medicines or putting the medicines within reach. Some people had consented to have their medicines administered by staff, who had completed the relevant medicines training. Occasionally people needed to have their medicines given with food which had been agreed with their GP. Staff confirmed they kept up to date with changes in people's medicines, "If someone's medication changes the first person to know rings the office, then everyone is messaged, so you'll know why there are different tablets when you get there."

Each person had a medicines administration chart (MAR) which identified all the medicines taken by them, some of which were supplied in blister packs. Staff signed these to confirm they had been taken. Concerns

were raised with us about the accurate completion of the MAR. On occasions staff had forgotten to sign this record. Staff had been guided to dot the record as they prepared the medicines to indicate they had been taken to the person. Care co-ordinators described how they observed staff to check their competency and if medicines errors occurred they would discuss these with staff at individual meetings and offer additional training if needed. Discussions with the registered manager centred on how the completion of MARs could be more robust and she agreed to discuss this with staff.

Good

Our findings

People were supported by staff who had the opportunity to acquire and develop their skills and knowledge to meet people's individual needs. As part of their induction new staff were registered for the new care certificate, which sets out the learning competencies and standards of behaviour expected of care workers. This also included working alongside experienced staff for as long as they needed. Staff confirmed, "When someone begins they shadow, so they learn how to get it right for people. If there was a problem with a member of staff they would get them to look at policies and maybe not move on to working alone straight away." Staff had been accredited as assessors for the care certificate, so they could carry out observations of staff performing their care and support duties.

Staff told us they had access to a range of training and were kept informed when they needed to attend refresher courses. They said they could ask for any training they thought relevant to meet people's needs and this would be provided such as end of life care or dementia awareness. A member of staff confirmed this saying, "We have clients with mental health problems now. They (Phoenix) arranged training which was good; you get advice from an outreach team." A comprehensive record detailed the training staff had completed and identified when this needed refreshing. Staff completed training considered mandatory by the provider such as first aid, moving and assisting and infection control. They also kept up to date with safeguarding and the Mental Capacity Act training. The registered manager described how the organisation kept up with current best practice through networking with local care providers, national guidance and completing accredited training. For example, staff were due to complete refresher training in positive behaviour support which had been endorsed by the British Institute of Learning Disabilities.

People benefited from staff who said they felt supported in their roles and who had regular meetings with senior staff to reflect on their training needs and the support they provided. This was a two way process with staff preparing feedback to be discussed as part of this meeting. Staff confirmed they had annual appraisals which focussed on their performance and their ongoing professional development. A member of staff commented, "I can always talk to a care co-ordinator and we have supervision every couple of months. You can also talk about issues in each area where we work and at staff meetings." The registered manager said individual and team meetings were used to explore with staff their understanding of key policies and procedures. For example, safeguarding was reviewed at each team meeting alongside other discussions such as developing new ways of working with people to give them more ownership and control.

We checked whether the service was working within the principles of the Mental Capacity Act (MCA) 2005. The 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's care records identified when they were unable to make decisions about their care and indicated whether they could make choices about any aspects of their support. Their care plans were supported by MCA assessments for people unable to make decisions and in the essence of the act, records confirmed which decisions had been made in their best interests and who had been involved. For example, ensuring people had their medicines and their finances were managed safely.

When people had appointed a lasting power of attorney (LPA), for property and financial affairs and/or health and welfare, the registered manager had verified this and a copy of the legal records had been kept. The registered manager said they had discussed the deprivation of liberty for one person with a social worker and their family and would submit the necessary documentation to the Court of Protection. 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.

People's care plans prompted staff to make sure they had sufficient to eat and drink and had access to food which reflected their dietary and nutritional needs. For example, one person liked to have juice and water left within reach so they could help themselves. Staff were observed making sure this happened. Another person's condition had been fully explored with them and staff described how they helped them to manage their dietary intake to help them to stay well. Occasionally people needed their food cut up or a soft diet provided and staff were aware of how their food needed to be prepared. People were offered choices about their food and drink; staff did not make assumptions about their personal preferences always checking with them in case these had changed or they wanted something different. A person confirmed this saying, "I choose my own food, it goes in the freezer and they microwave it and wash up."

People were supported to maintain contact with their GP and pharmacy if needed. Contact details for healthcare professionals had been noted in people's care records. Staff described how they monitored people's health and well-being and followed the agreed protocols to alert either their family or healthcare professionals if they had any concerns. When necessary staff called emergency services to attend to people and stayed with them as long as was needed. Staff confirmed, "We make sure people are ok before we leave" and "We keep them as well as they can be".

Good

Our findings

People had developed positive relationships with the staff supporting them. They told us, "You don't choose the (support) staff, but I like them all. They come in and talk, they are good to me" and "I need them, I couldn't have it any other way". Staff were observed being patient, caring and respectful. They commented, "Staff recognise professional boundaries; staff are passionate about their work and the people we support." People were observed chatting in a relaxed way with staff. A relative told the provider, "Fantastic, in the way mum's carers looked after her. She told me, 'oh dear, I am really enjoying life'. Undoubtedly, a lot of credit for that is due to your wonderful team for helping her keep well and happy."

People's backgrounds and preferences for the support they received were reflected in their care records. Staff understood people well and spoke with confidence about each person's individual needs and their social networks including people important to them. People had access to advocacy when needed; staff confirmed a few people had advocates. Staff said most people had family who advocated on their behalf.

People's diversity, cultural and spiritual needs were respected. One member of staff explained, "[name] mum has told me about the cultural things that matter to her because, although I know what she likes by her body language and expression it would have to be her family that explained some things. I did look her religion and culture up online but the family knows what is special to them". People had been asked if they had preferences about the gender of staff helping them with their personal care. One person said they did not mind, "but I prefer a man in the morning for my shower - so that's who comes". People's care records reflected these specific needs.

People's human rights were respected by staff. They made sure their personal information was kept confidential and only shared when needed. People's care records were kept securely in the office and electronic records were password protected. People's right to privacy in their homes was promoted and staff had been given guidance about maintaining professional relationships with people.

People's communication needs had been discussed with them and staff were prompted about their methods of communication. Staff were observed explaining in detail what they were doing and where they were leaving items for a person with a visual disability. They read back the daily notes to the person confirming with them instructions the person wished to be left for the next member of staff to visit them. Staff were directed to speak slowly and calmly with one person and to use photographs or objects of reference (for example showing them the full choice of drinks) with other people. People had been provided with information about their care and support. Some of this had been produced in accessible formats, using

photographs, pictures and large text.

Occasionally people became upset or anxious. Staff responded appropriately, telling us how they helped people to become calmer and to manage their emotions. The strategies they described reflected the guidance provided in people's care records. One member of staff described how they "reassure through touch" after a person had calmed down. Staff engaged with people positively, they knew what might upset people and tried to avoid these situations. Staff reflected about how they had successfully responded to one person's wellbeing over the years increasing their quality of life and decreasing their distress.

People were actively involved in making decisions about their care and support. Staff were observed talking through people's care needs with them, offering them choices and respecting their opinions. If people chose to refuse any aspect of their care this was respected. Staff did not hurry people, supporting them at their own pace and keeping them informed of what they were doing, seeking people's permission and following their lead.

People were treated with respect and dignity. On entering people's homes they knocked on the door and announced themselves. Staff ensured curtains in a room were closed when delivering personal care. Staff encouraged people to be independent in tasks they were able to do for themselves, showing patience and sensitivity. People's care records noted what they were able to do for example brushing their own hair; staff made sure a comb or brush was within reach for them to be able to achieve this. Staff talked about people respectfully telling us, "Staff communicate fantastically, they are so good and passionate about what they do."

People's preferences for end of life care had been discussed with them and records confirmed how they wished to be supported. For some people this had been produced in an easy to read format using pictures and photographs. A member of staff said they had completed end of life training to assess whether it was relevant to their needs and should be cascaded to other staff. She said, "It was relevant to everyone and it was really good."

Good

Our findings

People received care and support which reflected their personal preferences, interests, backgrounds and routines important to them. People told us they had been involved in developing their care plans to reflect how they wished their care to be provided. This had been done through discussion with them, their family and social or health care professionals. People confirmed their care records had been reviewed with them and if their needs had changed so had their care and support. One person told us, "Yes, I have a care plan; they sign it. [Name] has updated it for me, they read it to me because of my sight and I am dyslexic." A member of staff said, "When plans are reviewed they have anyone they want there - it's especially important if they are not verbal. Things get changed - for example, I supported someone to go to see the dietician with their mother (to discuss changing their diet)." Another member of staff commented, "We read through it with them. The plan can change any time - I put myself in their shoes, I would want it done that way if it was me."

People's care records reflected their strengths, what they could do for themselves and what they needed help with. A very detailed and personalised care plan described how staff should help them, what products should be used for personal care and people's routines to be followed. For example, once a week a different shampoo was used for one person and another person liked their meals to be given to them on a tray with a napkin. Care records also provided guidance for staff about the use of equipment. Photographs had been provided as an additional prompt for staff to remind them how to position cushions as part of a sleep system or use a standing frame.

People said they received their care at times which suited them and for an appropriate length of time. One person liked to get up early and go to bed late and this had been accommodated. Other people who lived together in shared housing also shared staff. Staff were clear about how they made sure each person received their allocation of staff support. Care hours were monitored by an electronic system which identified if longer visits or support time were needed to meet people's needs. Staff described how they were reviewing the visits to one person who had been advised to become more mobile, but for short periods of time. They said, "We are going to have a meeting to see how the hours could be broken up into different blocks." The registered manager confirmed people living in shared housing were able to review their living arrangements and reflect about whether they wished to make any changes.

Some people were supported with activities at home and in the community as part of their package of care. They told us about what they enjoyed doing such as swimming, drives to the countryside and holidays. Some people attended a day centre owned by the provider as well as social clubs in their local community. People were supported to keep in touch with their family and friends if this was included as part of the

service they received.

People said they did not have any concerns or complaints but knew who to talk with if they did. They could express their views about the service they received at their annual review of their care. Each person had a complaints procedure in their file and details about how to contact the office. People living in shared housing also attended various residents or tenants meetings where they could raise concerns. People said they would talk through issues as they arose and found the registered manager and the team to be "very accessible and approachable". Staff confirmed this saying, "If something crops up, it is dealt with immediately." The registered manager talked through one complaint which had been received and her response to this. This was comprehensive and evidenced the appropriate action had been taken to address the concerns raised.

Good

Our findings

People were involved in a variety of ways to give their views and express their opinions about how they would like the service they received to develop. Annual surveys were sent to people, their relatives, staff and health professionals to seek feedback about the quality of service provided. The annual business plan reflected these comments and identified improvements for the year ahead. One of these was to attain preferred provider status for the local authority. This was achieved helping the agency to expand further. People commented, "I have care from these people and they are very, very good and the charity is very good", "It is a very good service, I like it" and "I am listened to by staff and they help me". Staff responses included, "The charity has a positive standing within the community and knowing you are part of this is very positive for your career and job choice" and "I am ever so impressed with the work you do in the community and for service users". Staff talked with pride about their roles and were positive about the organisation they worked for and its achievements.

People were also invited to attend an "All service user meeting" with the board of trustees to talk about their experiences, to celebrate what had gone well and what they would like to achieve for the next year. A report was produced which included feedback from people and staff about what they wished the charity to achieve in the next year. People also agreed to meet monthly at a service user forum which would then feedback their views and requests directly to the board of trustees at their meetings.

People had benefited from external audits of their service by the local authority and inspections by their peers. Any actions identified from these external audits had been implemented and the registered manager said they had found the process beneficial as an additional method to monitor the quality of service provided.

Staff felt confident questioning practice and discussing issues with the management team. They told us they had raised concerns about their individual support being rushed. As a result they said, "The structure is going to be better; there's going to be another senior member of staff then we (team leaders) will be able to have some time away from hands-on work so we can get supervisions done on time." Staff confirmed the registered manager was open and available, "She is very accessible and very easy to talk to" and "She listens, you can express if you are not happy and can even ring up out of hours". Staff were also confident poor practice would be challenged by the registered manager and the appropriate action would be taken in response. Staff knew what was expected of them and there were clear processes in place to support them to develop professionally. Staff said they were able to "reflect on their performance" and the management team "listen to suggestions we have got". They commented, "We deliver as good a service as we can based

on the support times."

The visions and values of the service were described in the business plan as "provide excellent cost effective services for people", "ensure people can achieve their maximum potential and have full meaningful lives" and "deliver services that are person centred". The registered manager confirmed staff were introduced to the visions and values of the service during induction and monitored through supervision and observations of practice. She said, "Staff have been amazing, they move with changes to the service; they have excelled". She recognised the challenges of maintaining a stable staff team. The provider had reviewed staff levels and salaries. Additional senior staff were to be appointed so that there would always be a senior member of staff working, out of the office, alongside the staff team. In addition, by attending a recruitment fair at the local university, the registered manager hoped to encourage students to join them adding diversity to the team and a way "of seeing people with different eyes". New ways of working were being introduced to make care even more person centred. An outcome monitoring approach had been developed giving people ownership of their care and support.
Quality assurance systems monitored the management of complaints, the analysis of accidents and incidents and how people and staff were supported. In addition the trustees monitored the quality of service provided to people through quality assurance checks to the office, people in their homes and people in shared housing. The provider information return stated, "Quality assurance checks are completed by two trustees, who check records and gain feedback from service users and staff."

The registered manager was aware of her responsibilities under the Care Quality Commission (CQC) and submitted notifications when needed. CQC monitors events affecting the welfare, health and safety of people using a service through the notifications sent to us by providers. She was aware of the need to notify CQC of changes to the people they supported with personal care to make sure their registration details were kept up to date. She said she kept up to date with best practice and changes in legislation by attending local provider forums and continuing her own professional development.