Leonard Cheshire Disability

Living Options Outreach - Domiciliary 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?	Good

Summary of findings

Overall summary

About the service:
Living Options Outreach – Domiciliary Care provide personal care for people with complex physical health needs and additional conditions. Personal care and support is delivered from a detached bungalow in a residential part of Worthing, where each person has their own room and ensuite wet room.

People's experience of using this service:
• People told us they received safe care. They were supported by consistent and suitably trained staff. People received support to take their medicines safely and as prescribed. Risks to people's well-being and environmental safety were recorded and updated when circumstances changed. Lessons were learnt where appropriate to improve the service further.
• People's rights to make their own decisions were respected. They were supported to access health services if needed. People's dietary needs were assessed and where required people were supported with their meals.
• People received caring and compassionate support from the staff. The management team led by example and staff referred to people in a caring way. People were complimentary about staff and about positive, caring relationships they were able to form with the staff. Staff respected people's privacy and dignity and people were supported to be as independent as possible.
• The service was committed to assisting people to pursue their interests which created a sense of belonging and purpose. A range of activities were on offer to ensure a variety of opportunities which reflected people's wishes and interests. The manager was passionate about providing person centred care and this was reflected in every aspect of the service. People were empowered to help run and improve the service. People knew how to complain and told us where they raised concerns the management acted promptly to address these.
• The manager had a clear vision on the quality they wanted to provide at the service. There was a clear staffing structure and staff were aware of their roles and responsibilities. The provider had a number of quality assurance systems in place and there was a focus on further development. The service worked well with other partners and organisations.

Rating at last inspection:
At the last inspection the service was rated Good (report published 07 October 2016).

Why we inspected:
This was a planned inspection based on the rating at the last inspection.

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

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

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.
Details are in our Safe findings below.

Is the service effective?

Good

The service was effective.
Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.
Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive.
Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led.
Details are in our Well-Led findings below.

Living Options Outreach - Domiciliary Care

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team consisted of one inspector.

Service and service type:
This service provides care and support to people living in a supported living setting, so they can live in their own home as independently as possible. People's care and housing were provided under separate contractual agreements. CQC does not regulate the premises used for supported living; this inspection looked at people's personal care and support.

The service had a manager who had applied to be registered with the Care Quality Commission. This means the provider is 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 72 hours' notice of the inspection visit because we needed to be sure the management would be in the office. The manager then contacted people using the service to ask their permission for us to visit them in their homes.

What we did:
Providers are required to send us key information about their service, what they do well, and improvements

they plan to make. This information helps support our inspections. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law.

We visited the office location on 5 April 2019 to see the manager and service manager. On the same day, we visited the supported living setting with the manager. We spoke with three people using the service, one senior support worker and one support worker.

We reviewed care files of two people using the service and medicine records. We checked training records for all the staff employed. We looked at a range of records about how the service was managed.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse:
• People told us they felt safe. One person said, "I feel very safe, this is my home. Staff help me, to keep me safe." Another person said, "I am safe living here. We have staff here to help us. I like living here."
• The provider had policies and procedures in place to safeguard people from abuse. Staff received training in safeguarding people. They were knowledgeable about types and signs of abuse. They knew they needed to report any suspected abuse and/or discrimination to the manager, and if necessary the relevant local authority, safeguarding team, police and CQC.
• The manager was aware of their responsibility to liaise with the local authority if safeguarding concerns were raised.
• Systems were in place to ensure people received the support they needed with the management of their finances. Checks were carried out to minimise the risk of financial abuse.

Assessing risk, safety monitoring and management:
• Risk assessments were in place included risks specific to people using the service and to the staff supporting them. These included risks of people using public transport, risks with cooking and risks associated with engaging with strangers when out in the community. Least restrictive risk management plans to minimise the risk of people and staff being harmed were recorded. Staff were knowledgeable about the risks to people's safety and about the guidance they needed to follow to keep people safe.
• People's care plans contained details about people's behaviours that might challenge. Information about recognising triggers for a person's particular behaviour and pro-active strategies for staff to follow to support the person were recorded. Staff received training in 'behaviour awareness' and in understanding and managing people's behaviour that challenged. One staff member said, "We are observing people and you can normally assess their mood. You can tell by their reactions or if they were a bit low, then this would indicate a possible issue, for us to support."

Staffing and recruitment:
• People were supported by consistent staff. People told us they felt there was enough staff. One person said, "I love the staff. We have the same staff and they are good at what they do."
• Staffing levels were calculated according to people's needs. Arrangements were in place to ensure there were enough staff to support people safely and to ensure people's needs were met. This included receiving the support they needed to participate in activities and outings.
• The provider continued to follow a safe recruitment system to ensure staff were suitable to work with people.
• Staff told us the on-call system ensured they could always obtain advice and support from senior staff.

Using medicines safely:
• People, if needed, were supported to take their medicines safely and as prescribed.

• People's care records contained lists of people's prescribed medicines, this included people that self-medicated.
• The management team ensured people's medicine records were completed accurately. If the medicine record was not fully completed this was followed up to ensure there was a valid reason, such as a person declining to take their medicines.

Preventing and controlling infection:
• Staff completed training in infection control and food hygiene to keep people safe from harm. They knew the importance of frequently washing their hands, such as after supporting people with their personal care. We saw a person using the service wash their hands before preparing a meal.
• Protective equipment was available for use as needed to help reduce the spread of infection.

Learning lessons when things go wrong:
• A system was in place to report, record and monitor incidents and accidents to ensure people were supported safely. Any incidents and accidents were analysed to identify trends and patterns to reduce the likelihood of their re-occurrence.
• The manager provided us with an example of an incident that happened when a person was doing their laundry. There was a risk of harm for one person who used a wheelchair, because the corridor was narrow. The provider made arrangements for the washing machine to be moved to a more accessible part of the property. This has protected people's safety and enabled people to do their own washing independently. One person told us they used a hand picker to get the washing out of the machine safely. They said, "It has made a big difference. It was frustrating before."

Good

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. People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• People's care and support records showed the service had assessed their needs with their involvement and, when relevant, their relatives' participation. People's preferences and aspirations were identified. Guidance was in place for staff to follow to effectively deliver personalised care and to provide people with the support they needed to achieve their chosen goals.
• People's support plans included information about people's background and their personal relationships, cultural, religious and dietary needs and preferences. This helped staff more fully understand people's individual needs and effectively provide their care.
• People's care and support needs were regularly reviewed with their involvement and were updated when there were changes in their requirements and wishes.
• People using the service confirmed they made decisions about their care and other aspects of their lives. These included choices about when they wanted to get up, what they wanted to do and what they wanted to eat.

Staff support: induction, training, skills and experience:
• Staff had the knowledge, skills and experience to support people effectively. People told us they felt staff understood them and provided them with appropriate assistance and support when they needed it.
• People were supported by staff who had ongoing training that was relevant to their roles. Staff had additional training around people's specific conditions if needed, for example, catheter care and epilepsy awareness.
• Staff were encouraged to study for vocational qualifications in health and social care. New staff followed the Care Certificate, a work-based, vocational qualification for staff who had no previous experience in the care sector. New staff shadowed experienced staff.
• Staff received regular supervisions and appraisal of their development and performance. They told us they felt very well supported by management and other staff. They had regular one to one meeting with their line manager to discuss their care practices and development opportunities.

Supporting people to eat and drink enough to maintain a balanced diet:
• At the time of our inspection people did not have any dietary requirements.
• People spoke of buying foods they liked. During the inspection we saw people make decisions about the food they wanted to eat.

Staff working with other agencies to provide consistent, effective, timely care:
• The manager had good relationships with the local medical practice and with the pharmacy. Issues were addressed as needed.
• Changes in people's needs were shared with commissioners [representatives of public bodies that

purchase care packages for people], when needed. For example, one person had expressed the desire to live more independently in the future. This had been shared with the funding authority to explore further.
• Information was shared with appropriate agencies when people needed to access other services such as hospitals.

Adapting service, design, decoration to meet people's needs:
• The provider, as part of the person's assessment of care, ensured any adaptations to the bungalow needed were carried out by an agreed external contractor.
• For example, the provider had adapted the building to install rise and fall work surfaces. This meant they were able to move up and down depending on the height of the person/wheelchair. This enabled people to do their own washing and drying up.
• A reduction hob was installed to enable people to do their own cooking which reduced the risk of scalding. Pull out work services were put in place to enable people to cut up vegetables and do baking. The water system for making drinks was a 'one touch button' system, which enable people to make their own drinks and remain as independent as possible.

Supporting people to live healthier lives, access healthcare services and support:
• People were supported to live healthier lives and had access to a range of healthcare professionals and services.
• People attended appointments with professionals such as their GP, dentist and optician. As needed, people were supported to make referrals to specialists, such as occupational health and physiotherapists where people had difficulties with their mobility.
• Care records included a 'This is Me' which provided information in an accessible format about people's care needs, likes, dislikes and preferences. The document went with people if they had to be admitted to hospital, to provide guidance for healthcare staff.

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. We checked whether the service was working within the principles of the MCA.
• One person said, "I make my decisions, not the staff. They explain things to me, to help me decide on things, but I choose what affects me. I like that."
• People's rights to make own decisions were respected. People's support plans included details about people's ability to make decisions about their lives and care. These included day to day decisions to do with their care and activities they chose to participate in.
• Staff knew it should be assumed people had the capacity to make decisions about their care and other aspects of their lives unless assessment showed otherwise. They knew what people's relatives, health and social care professionals might be involved in best interest decisions as needed. One staff member said, "You assume everyone has capacity to make their own decisions, how they want things done. I am here to support their decisions, not to take away and not to make their decisions. They make their own decisions here."

Good

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. People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity:
• People using the service told us staff were kind to them and treated them well. We observed very positive interaction between staff and people using the service. A person who had limited verbal communication also used finger spelling. Staff understand this really well. The person was able to teach us how to communicate using this technique. They confirmed they liked the support worker and the manager.
• The provider had policies and procedures that ensured people's equality and diversity needs and human rights were met by the service. Staff told us they had received training and learning about equality, diversity and human rights. The spiritual or cultural needs of people were outlined in their care plans and assessments.
• Information about people's individual equality and diversity needs, including sexuality needs, was contained in their support plans. Staff were knowledgeable about people's differences and knew about the importance of respecting people's diversity and human rights. A support worker told us, "We are all equal. Their rights are no different to mine."

Supporting people to express their views and be involved in making decisions about their care:
• People told us the staff knew people's preferences well and knew how people would like their care to be delivered.
• People's individual communication needs were assessed and recorded in their care plan. People had access to assistive technological devices that supported them to communicate. One person used a computerised system, which enlarged the size of the information being read, which helped them to communicate their wishes. Staff received the training they needed to help them support people to communicate their wishes and choices.
• Staff knew when to involve people's relatives, advocates and others in decisions about people's care. People were supported to communicate their views and were involved in planning their activities and daily life.

Respecting and promoting people's privacy, dignity and independence:
• People told us staff respected their privacy and dignity. Staff received training about treating people with dignity and respect and knew the importance of respecting people's confidentiality and not speaking about people to anyone other than those involved in their care.
• People's care records were stored securely so only staff could access them.
• One staff member said, "We always knock on the door before going in. If supporting people to shower, we make sure they are covered in intimate areas. We always respect the person, no matter what we are doing. We respect their dignity."
• People's independence was supported by the service. People's support plans included guidance to promote and support their independence. They included information about what people could do for

themselves and where additional support may be needed. During the inspection a person using the service prepared their own lunch with minimal supervision from a support worker. One person told us about the places in the community they visited with minimal support. People were encouraged to participate in cooking and cleaning. The approach continued to be staff doing activities 'with' people rather than 'for' people. We observed staff enabling a person to make a cup of tea.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs. Services were tailored to meet the needs of individuals and delivered to ensure flexibility, choice and continuity of care.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• People received personalised care and support specific to their needs and preferences. There was an good understanding of seeing each person as an individual, with their own social diversity, values and beliefs. This was evident from staff within all roles. For example, staff valued people and knew their preferred daily routines, like, dislikes and wishes. Care plans contained information such as the person's past history, for staff to know how they liked things done.
• People told us they received the assistance and support they wanted from staff. Staff demonstrated they knew the people they supported well and could describe how people's needs were met by the service.
• All providers of NHS care or other publicly-funded adult social care must meet the Accessible Information Standard (AIS). This applies to people who use a service and have information or communication needs because of a disability, impairment or sensory loss. There were some people using the service that were unable to read and/or had difficulty understanding information. Some people had electronic devices to help them with their communication and to access information. Care plans were presented in a format which contained pictures and photographs to make them easily understood by people.
• People were supported by staff to plan and timetable a range of activities they wanted to take part in. These activities were based around people's individual interests such as accessing community facilities and amenities, visiting a local leisure centre to participate in activities, attending college, going to football matches, doing crafts and shopping for personal food items and toiletries.

Improving care quality in response to complaints or concerns:
• The service had a complaints policy and procedure. People using the service told us if they had a worry or complaint about the service they would speak with a member of staff. They were confident any complaint would be responded to appropriately by the service.

Good

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. The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:
• People said the service was well-managed. One person said, "I like the manager. He visits regularly to see us." Another person said, "The manager and staff are very good. They listen."
• The manager planned and delivered person-centred care and consistently achieved positive outcomes for people. This considered all aspects of a person's life, addressed people's health needs promptly and maintained links with their local community. This was evidenced through feedback received and records reviewed.
• The manager told us they ensured they spent time every week at the service, so they monitored the care and support people received and the culture of the service.
• The provider promoted an open and transparent, 'no-blame' culture. A staff member said, "My goal is to help people become more independent. Live their life and do what they want to do. Supporting people to do it. It helps that this manager, is so approachable. His door is always open. He is always contactable and he visits people here, normally weekly, just to see how they are and are they happy with the support being provided? When people haven't been happy, the management team learn why, and support us to improve where we can. It's really good now."
• The manager demonstrated how they fulfilled their responsibilities for duty of candour and took the appropriate action to inform all the relevant people when incidents happened.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• The manager spent time with people and staff to ensure a high standard of care was delivered.
• Staff understood the requirements of the CQC regulations and how to meet these. Staff told us the remit of CQC and how we inspect had been discussed at a team meeting. The rating achieved at the last inspection was on display at the office. Notifications the manager was required to send to CQC by law had been completed.
• The staff were aware of their roles and worked well as a team. Staff told us there was a 24 hour on call system to access if they needed support outside of office hours.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• People told us they were happy with the service they received. They had the opportunity to participate in tenants' meetings, where they discussed the service, planned holidays and received learning such as safeguarding and safety matters.
• The service understood and supported the diverse needs of people using the service and staff. This

included respecting people's religious and cultural needs, such as religious festivals. Staff spoke positively about the respect, support and understanding the provider and staff had of people's differences.
• Yearly surveys were encouraged for people and relatives to complete, although people had chosen not to complete these.

Continuous learning and improving care:
• The manager had a number of quality assurance systems in place. These included audits of medicines records, care records and spot checks. Audits were effective in identifying any issues or underlying themes to drive improvement.
• Effective communication systems were in place to ensure staff were kept up to date with any changes to people's care, staff learning and support arrangements and organisational changes.
• There was an emphasis on continuous improvement. For example, the manager monitored complaints, accidents and other occurrences monthly to identify any lessons to learn. The manager encouraged staff to also complete surveys on how they were enjoying their role, whether they feel supported and where the provider could improve. We were told all comments received were positive. However the results had been formulated into one documented for all staff employed by the provider, so we were unable to view the results of the staff survey for this location.

Working in partnership with others:
• The provider had continued to develop their links with the local and wider community, and other organisations to support people's preferences and meet their needs. People knew their neighbours and had built relationships with people in the community, for example at their local shops.
• The manager and staff continued to work in partnership with other services, for example their GP, community pharmacists, advocates, community nurses and occupational therapists to ensure people's needs were met in a timely way.